THE CHILD IN RESIDENTIAL TREATMENT: A FOLLOW-UP STUDY

An Abstract of a Dissertation by
Earl P. Kelly
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Drake University
Advisor: Stuart Tiedeman

The Problem. The problem of this study was to determine whether certain variables relating to the child requiring placement in a residential treatment center were associated with the child's eventual positive or negative adaptation within the community. Such variables consisted of preadmission characteristics, selected activities during residential treatment and the discharge phase. The Health and Sickness Scale (HSS) was used at point of discharge to predict eventual adaptation. The selected variables were compared with the nature of the child's adaptation, either positive or negative, at the time of follow-up.

Procedure. A total of 199 youths had been placed in the Orchard Place programs since its inception in 1965. Of these, 138 could be located and were included in this study. Two judges reviewed the casefiles of each youth and recorded data pertaining to age at admission, number of preadmission foster home placements, whether the child had received any group care placements prior to the Orchard Place admission, whether the child was living with parent(s) prior to admission, the actual length of the residential care received, the frequency of parental contact during the child's residential treatment and the disposition of the case at point of discharge. Additionally, the Health Sickness Scale (HSS) was used by the judges at point of the child's discharge to measure the outcome of the treatment experience. Contact was then made with the former subject or with relatives or social agencies requesting participation in the study. A structured questionnaire was used to collect responses from participants regarding the subject's adaptation to the community since the time the subject was discharged from Orchard Place. Each subject was evaluated as either positive adaptation (+) or negative adaptation (-) depending upon selected criteria. The responses on adaptation were compared with each of the hypotheses of the study and Chi-Square tests were applied to test at ($p < .05$) for independence of each hypotheses. The structured questionnaire additionally included other questions including such items as school adjustment and current grade

placement, if any, highest educational level attained, church affiliation, friendships, overall current adjustment status, and involvement in psychiatric outpatient counseling. An attempt was also made to assess when a negative adaptation occurred from point of Orchard Place discharge.

Findings. The results of the study indicated that of the seven hypotheses three were statistically significant with adaptation: preadmission group care with adaptation ($p < .001$), whether the subject was with parents(s) prior to admission ($p < .001$) and disposition at discharge ($p < .001$). No statistically significant relationship was found for length of care, frequency of family involvement, age at admission and preadmission foster family care. The HSS was found significant with adaptation ($p < .001$). In terms of educational questions it was found that those rated at (+) adaptations tended to do better in school, attain higher levels of educational achievement and if in school, fewer of the (+) group were found to be in special educational programs. Adaptation with church attendance ($p < .05$) and friendships ($p < .01$) were found to be significant. Overall or global assessment of the subjects' current status was significant with adaptation at ($p < .001$). Involvement with further outpatient psychiatric counseling was not significant with adaptation. Another finding was that of those who were evaluated as manifesting (-) adaptations about 45% occurred within the first three months following the discharge.

Conclusions. The preadmission experiences of the children apparently hold much significance for eventual adaptation. The HSS was found to be useful in this study and has application for assessing adaptation if used at point of subject discharge. Returning the child home following treatment was a significant factor in long range adaptation. An (+) adaptation rate of 69.34% was computed for the target group and those who were evaluated as (-) adaptations may represent a special population group who require intensive services.

Recommendations. Further effort must be made by the agency to assess and meet the needs of troubled youths who are found in residential programs. Of particular import is the time soon after discharge when attention needs to be given to the process of re-entry into the community and family. Consideration should be given to expanding use of the HSS as part of future assessment efforts and further attention should be focused on what were the essential factors in assisting the (+) group to successfully adapt to the community following the residential experience.

THE CHILD IN RESIDENTIAL TREATMENT:
A FOLLOW-UP STUDY

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Earl P. Kelly

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by

Earl P. Kelly

Approved by Committee:

Stuart C. Tiedeman
Chairman

Terry L. Linnerman

Leonard Kaplan

Edward Kapler

Lloyd J. McNeely

Dean of the School of Graduate Studies

TABLE OF CONTENTS

Page

APPENDIXES

LIST OF TABLES

Chapter 1

INTRODUCTION

The area of services for the child who manifests disordered behavior requiring separation from home and placement in an institutional setting is a timely and complex topic for study. In 1969, the first national study of children's institutions revealed that each night some 150,000 children and adolescents go to bed in approximately 2,500 child caring instituitons in the United States and territories.[1] Of such children roughly 75 percent, or 110,000 children, are judged to be exhibiting disordered behavior to some degree.[2] Not all of the child-caring centers noted provide therapeutic treatment services. Many of these settings are for delinquent and predelinquent youths while others provide detention, maternity care or other specialized youth services care. According to the Joint Commission on Mental Health of Children in 1970, there existed approximately 296 residential treatment centers which provided intensive or total care to the child who

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[1] G. Pappenfort and W. Kilpatrick, "Child-Caring Institutions, 1966: Selected Findings from the First National Survey of Children's Residential Institutions," Social Service Review, XLIII (December, 1969), 450.

[2] Ibid., p. 451.

required separation from home.[1] The child who is placed in a residential center typically is placed following the child's utilization of other services offered in the community to modify the child's disordered behavior.

Estimates of the number of youths who require residential care services vary widely. The best figures available suggest that 0.6 percent of the nation's children are psychotic and 2 to 3 percent suffer other forms of emotional disturbance.[2] One estimate is that 1,400,000 children under eighteen need immediate psychiatric care.[3] These are important data for residential centers inasmuch as such centers find it increasingly difficult to provide services to those requiring care. For instance, in the same year in which it was determined that 1,400,000 youths were seriously disturbed there were slightly more than 8,000 children in residential treatment centers.[4] Often because there are not sufficient numbers of residential treatment centers, children may be placed in inappropriate settings where their problems may become more severe and exacerbated.

Currently, such centers are being examined to

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[1] "Report of the Joint Commission on Mental Health of Children," in Crisis in Child Mental Health: Challenge for the 1970's (New York: Harper & Row, 1972), p. 272.

[2] Ibid., p. 257.

[3] Ibid., p. 272.

[4] Ibid.

determine why more children are not able to receive services; moreover, increasingly such centers are being asked to justify the effectiveness and impact of their services. Certainly a component of the criticism has been related to the spiraling cost of residential care. For instance, the cost of such care is generally estimated at between $10,000 to $18,000 per child per year.[1] Often the costs are directly related to attracting and retaining highly skilled professional staff members who may command competitive salaries in the community. However, effective residential treatment intervention may reduce subsequent suffering and may well save later costs to the community.

In spite of rising costs and the limited number of young people served, it is apparent that with population increase and family breakdown there will be more who will require treatment in a residential setting. In view of these factors it is increasingly important for residential centers to determine how they may be more efficient in terms of increasing their capacity to provide services and to determine the nature of the impact they are having upon target populations.

RATIONALE FOR THE STUDY

This study has several purposes:

The first purpose of the study was to explore some

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[1] Ibid., p. 271.

questions relating to variables of age, parental involvement, living origin prior to residential admission, length of care, and disposition at discharge.

The second purpose was to provide some measure of relative impact of the treatment program upon the target population.

Thirdly, the study attempted to identify when a negative adaptation, if it occurred, developed with respect to the time of discharge from the agency program. Analysis of this information may enable the agency to allocate resources, or locate resources to reduce the incidence of negative adaptation. Analysis of this area was impressionistic, based upon the individual clinicians' opinions of adaptation incidence.

The final purpose of the study was to explore a process through which the staff as a group could examine what they knew about treatment methods and results. It was anticipated that this examination would allow the agency to define methods and organizational goals more clearly and definitively.[1]

STATEMENT OF THE PROBLEM

Mayer noted residential treatment centers were being challenged on results of treatment, the amount of

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[1]R. P. Durkin and A. B. Durkin, "Evaluating Residential Treatment Programs for Disturbed Children," Handbook of Evaluation Research, ed. L Guttentag and E. Struening (Beverly Hills: Sage Publications, 1975), p. 276.

time taken to achieve results, high costs and the relationship of the treatment center's work to total community need.[1] Suchman further noted that social service agencies as well as other societal institutions are required to offer some evidence of legitimacy to justify continued support from society. Part of this thrust is contained in what Suchman believes is society's attempt to provide better solutions for correcting disordered behavior.[2]

Many of the concerns directed toward residential centers are valid. In part, residential centers may not have a clearly defined organizational system of goals which would enable them to determine what clientele can benefit from their programs. Even though many agencies attempt to determine whether a client can be helped, a major difficulty in the area of human services is the unique difficulty of predicting precisely who can best be served by a given program. This study then is a beginning effort to examine a residential program to determine common characteristics of those children served most successfully.

THEORETICAL FORMULATION

This study followed children who received treatment

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[1] M.F. Mayer, "Program Evaluation as a Part of Clinical Practice: An Administrator's Position," Child Welfare, LIV (June, 1975), 381.

[2] E.A. Suchman, Evaluative Research (New York: Sage Publications, 1967), p. 2.

services from a specific residential treatment program at Orchard Place, Des Moines, Iowa. The reporting of data was descriptive in nature and attempted to describe trends and patterns occurring with the client group.

Furthermore, this study utilized as a conceptual foundation the concept of client adaptation as operationally defined in the 1966 Allerhand study. In that study an outcome approach was utilized through which adaptation and adaptability were significant factors in evaluating the status of the subject. Adaptation then was defined as:

> . . . behavior resulting from an individual's application of his available adaptability to circumstances in the perceived environment with which he desires continuity . . .[1]

The adapted individual is able to rely upon internal and external resources to respond to environmental demands. Such demands or expectations may or may not be successfully met by the person. This is a function of what Allerhand defines as "adaptability," which is a "state of readiness to meet demands on a selective basis."[2]

> A particular level of adaptability is the current integration of the individual's structural development with the resultant interaction between him and all the factors so far included in his life space, i.e., the sum total of his experiences.[3]

Ideally, the residential center experience provides

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[1] M.E. Allerhand and R.E. Weber, Adaptation and Adaptability: The Bellefaire Follow-Up Study (New York: Child Welfare League of America, 1966), p. 3.

[2] Ibid.

[3] Ibid.

the client with experiences which foster the client's overall capacity not only to fulfill society's role expectations but to respond to evolving structural expectations from the environment of which he/she is a part. The process in which this is realized is intensive re-education which enables the client to gain increasing mastery over the environment and thereby exercise more control in meeting needs.

This study utilized an index of recidivism as reflective of the client's adaptation and adaptability functioning. The client who is unable to fulfill role functions within society may require additional services from the designated institutions providing remedial help. Often such clients require services from the mental health delivery system and in some cases the client may require incarceration to protect society. Specific definitions of adaptation have been operationalized and will focus specifically on psychiatric hospitalizations and delinquent activity of former residents. Determining adaptation patterns then offers a relative index of adaptation for former residents.

This investigation has also focused upon the level of adaptation by using an instrument (Health Sickness Scale--(HSS) at the exact time of discharge. The study generated data in terms of adaptation prediction based upon ratings of the resident's overall status at point of discharge. This approach is in keeping with Durkin and Durkin's view that:

> . . . since maturational and situational influences may confound measures of post-treatment outcomes, attempts to measure the outcome of treatment can probably be best measured at discharge with the recognition that long-term adjustment may be a different question . . .[1]

They noted to the degree the agency program takes into account the other environmental and maturational variables through such means as family therapy and aftercare services the outcome of treatment and subsequent adjustment tend to merge. Thus, treatment outcome for the client tends to become more closely related to subsequent adaptation.[2] The agency system wherein this study took place did provide for the other variables noted through service extensions. This provision combined with Durkin and Durkin's viewpoint of discharge significance adds theoretical support to the study's clinical application.

In striving to understand what occurs to the child following treatment it is necessary to outline the theoretical orientation of this study, which holds that the child requiring interventive services is the "at risk" child. The concept of the "at risk" child generally refers to the child marginally supported by the family of origin as manifested by parental support structures, financial resources for the child, and similar psychosocial structures interacting with the environment. Such children then are "at risk" in terms of not receiving a combination of psychosocial resources enabling them to progress develop-

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[1] Durkin and Durkin, p. 291.

[2] Ibid.

mentally. Often such children may require care in a residential treatment center or receive remedial services due, in part, to deficits of a developmental nature.

In recent years a number of writers have been studying the developing child from the standpoint of social phenomena impinging upon the child. This interactionist frame of reference is represented by writers such as Erickson, Allport, Rogers, Kelly and Maslow, who have tended to examine the interaction between a person and environment, how a person is shaped and, in turn, how that person shapes the external world. Such writers have demonstrated that it is no longer appropriate to focus solely upon intrapsychic functioning nor upon the environment exclusively, but, rather, on the interaction of the two spheres.[1]

Such interaction between the person and the environment must inevitably rest upon the quality of the developmental process experienced by the person. Children who have developmental lags resulting in problems with identity and self-concept represent a population of youngsters not capable of functioning meaningfully in society. Such children, upon entering a residential center, are the focus of intense remedial efforts. Professional staff bring to such children talents and energies focusing upon specific areas of developmental need for the child. As the child's

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[1]Allerhand and Weber, pp. 2-3.

needs are defined, understood and fulfilled, the child is enabled to increase his mastery over the environment and thereby improve his feelings of worth and dignity. Developmental lags however, are not always easily or quickly treated. Indeed, one of the concerns relating to the nature of residential treatment experience is that often it may be viewed as a panacea for meeting the child's total needs.

One of the orientations of this study is that the child who moves into the residential experience may require a continuum of services within the life cycle. Rather than the residential treatment experience being a totally inclusive curative process, it is more accurate to see such youth as requiring constant and intense support from significant others through the life cycle. This, as Erickson has pointed out, is developmentally accurate for persons generally.[1] To extrapolate this to a group of youths who have encountered identity problems is not difficult. Thus, one of the areas carefully examined was the analysis of the relative effect of the residential experience for disordered youth. What happened to youths after discharge? If these children did not adapt successfully to society, how long were they able to function positively in the community? Additionally, are there other common characteristics regarding this particular group in terms of interaction with the external world?

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[1]Eric Erickson, Childhood and Society (2nd ed.; New York: W.W. Norton and Co., 1950), pp. 403-423.

Because of early failure to interact successfully with the environment it is expected that such "at risk" children will encounter further problems in interacting with a complex changing environment. This study also attempted to gather data on this point.

Finally, the study also holds as a theoretical orientation that the relationships between variables such as age, parental involvement, frequency of pre-foster care placement, living with parents prior to the residential admission, length of care, and disposition at discharge need to be examined with respect to adaptation effect.

HYPOTHESES

Since 1965 the agency has received into placement, children requiring actual treatment services, whereas the previous orientation was simply to provide care and maintenance. As the program expanded, the agency became interested in program evaluation, and this study was designed to use specific variables to determine any correlation with the subject's adaptation status at follow up. Specifically, the data were collected to determine if adaptation was related to the client's preadmission status, the amount of family involvement and length of care, and the postplacement experience. The study also attempted to pinpoint any times crucial to adaptation after discharge.

First, what were the child's preadmission life experiences? Were most of the children entering directly

from foster home placements? How many of them were coming from natural parents' homes? How many were coming from group home placements? The sixties saw different philosophies emerge relative to the care of disordered youth which had an impact upon the type of child entering Orchard Place. More difficult-to-treat children were being seen in such centers due to the expansion of community services.[1] Such children often presented different and complex backgrounds in which many alternative systems of care were attempted before residential admission.[2] Questions such as, "What are the possibilities of successful adaptation for a child who has experienced several group care placements before entering residential care?" confronted staff. It was hypothesized that certain variables might have significance for long range subject adaptation patterns.

Second, with respect to the program at Orchard Place, it was hoped that data could be obtained about essential variables and how they, in turn, influenced long term adaptation patterns of clients. Family involvement was an essential variable influencing subject adaptation. A number of authors have cited parental involvement as essential to the child's care and prognosis. Another key

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[1] Alfred Kadushin, Child Welfare Services (New York: Macmillan Co., 1967), p. 550.

[2] Kadushin, p. 552; Lydia Hylton, The Residential Treatment Center: Children, Program and Costs (New York: Child Welfare League of America, 1964), p. 14.

variable was length of care. For those children who left or were discharged as planned did this variable correlate with positive adaptation status of the subject at follow up?

Third, it became increasingly important to predict the subjects' eventual adaptation or postplacement experience. It was the writer's belief that a standardized instrument would be helpful as a method of obtaining a "numerical picture" of each subject at the time of discharge from Orchard Place. Such a value, from 0 to 100 was then correlated with the status of the subject at follow up. The utilization and development of such an instrument could possibly be helpful in determining the likelihood of post-placement adaptation. Thus, if a relationship could be found between a subject's improvement during treatment at Orchard Place and functioning at follow up, it could be postulated that gains during treatment were effective on later functioning of the client.

Fourth, it was believed that information must be collected to identify the relative effect of residential care across the spectrum of clients who had moved through the program since its inception. Furthermore, the identification of time frames from the point of Orchard Place discharge could serve to identify when subjects moved into a negative adaptation, if at all.

Based upon the four points above, the following hypotheses were formulated:

1. Positive/negative adaptation is unaffected by age at admission.

2. Positive/negative adaptation is unaffected by the number of preadmission foster care placements.

3. Positive/negative adaptation is unaffected by group care/non-group care placements.

4. Positive/negative adaptation is unaffected by living with parents prior to admission.

5. Positive/negative adaptation is unaffected by parental involvement.

6. Positive/negative adaptation is unaffected by the length of residential care.

7. Positive/negative adaptation is unaffected by disposition at discharge.

Seven contingency tables were developed to test the hypotheses. These tables are presented in Chapter 4.

In addition, the writer believed that a number of other tables would be useful in giving a comprehensive view of how subjects were faring at the time of follow-up. Such tables range from demographic data to results of participation in further psychiatric therapy and will be discussed in Chapter 4.

ORCHARD PLACE: THE SETTING

The Des Moines Children's Home opened in 1886 as an agency to provide shelter and care for orphaned children. From 1886 until the early sixties the agency functioned in this capacity. At that time it became apparent that a reorganization of program would eventually be required for the agency to continue functioning effectively. A

declining population of youths requiring custodial care was evident. Further, a major fire had occurred at the facility in 1962 which required examination of the viability of completely refurnishing the third floor of the facility.[1] Ultimately it was decided to reorganize the program.

The agency was reopened as Orchard Place, a residential treatment center for emotionally disturbed children, in February, 1965. From this beginning, the agency now has the capacity to treat 57 children in three different residential programmitic units. The first unit, a residential center, has a total occupancy of forty beds, the Kenyon Street Group Home unit, ten beds, and the Porter House Diagnostic and Prevention Unit, seven beds.

The staff serving the agency population function in three different divisions: the youth service staff, who provide services to the child on each living unit; the therapy staff, who provide services on an individual basis to the child and family; and the special education staff, who provide services for the child in residence. A team approach is utilized in working with the children.

The child's family participates in the treatment program through close involvement in formulating major decisions about their child and assisting in evaluating

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[1] M.R. Crow, "An Analysis of the Development of Orchard Place: A Residential Treatment Center for Disturbed Children" (unpublished Ed.D. dissertation, Drake University, 1976), p. 70.

services received from the agency. Overall, unless the parents sanction their child's proposed treatment program, residential care may be contra-indicated.

Psychological and psychiatric services are provided each child in residence. Regular psychiatric reviews are held for each child in residence. The purpose of such reviews is to insure that effective treatment programming is continuing.

There are a number of admission requirements which need some elaboration. First, an admission criterion is that the child has "average" intelligence. While an admitted child may be functionally retarded, the child who is mentally retarded is not appropriate for the program. Second, the child must not have incapacitating physiological handicaps. Minor physical handicaps will not preclude admission. Third, the child must have an involved parent or parent surrogate in the community. This requirement assists the child and parent to understand that the agency does not intend to replace the child's parent. Fourth, children admitted generally range from 6 - 16 years of age.

Children who have been referred to Orchard Place for residential treatment have been moderately to severely emotionally disturbed. Periodic reviews for accreditation of the agency's program by the Child Welfare League of America and the Iowa Department of Social Services insure that the program is providing high quality care for the children.

From a philosophical viewpoint, the agency has utilized a psychoanalytic approach to understanding the child. Although this approach has been viewed as a central approach, the agency has been involved with family therapy in approaching the child and has also utilized behavior therapy for certain children in residence who seem to respond most effectively to such an approach. Overall, the agency has attempted to utilize a flexible approach in working with children to insure that the needs of each child are primary in determining the most effective helping process.

Chapter 2

REVIEW OF LITERATURE

At the outset it is imperative to note that few studies have been completed relating to a follow-up of adolescents and preadolescents who have received treatment services in a residential treatment center. For this study the review of the literature has been expanded to include both residential treatment centers as well as psychiatric treatment centers. Both units are closely related and overlap in programmatic function and purpose. Often, however, the psychiatric unit is located in a general hospital setting and may be geared toward symptom alleviation as opposed to personality reorganization or a definitive treatment experience.

Gossett and Lewis noted only thirteen long-term psychiatric follow up studies have been completed in the last thirty years.[1] A number of studies have, in fact, been developed since their observation and will be reviewed here, yet the number of studies certainly appears limited. In part, the limited number of studies may be a function of problems of data collection, design issues and related

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[1] J.T. Gossett and others, "Follow-Up of Adolescents Treated in a Psychiatric Hospital: A Review of Studies," American Journal of Orthopsychiatry, XLIII (July, 1973), 602.

difficulties. Sargent noted: "the importance of follow-up is equaled only by the magnitude of the methodological problems it presents . . ."[1] As an illustration of some of the methodological issues involved in the follow up type of research, the following sample proves interesting:

> . . . Even the deceptively simple question "How is the patient now better or worse?" runs into difficulties. The phrase "better or worse" involves both social value systems (too broad a context for research, however important it may be) and individual treatment goals too specific to be much use in the selection of criteria. . .[2]

A number of points of view raised by Sargent have suggested follow-up data, assuming it can be obtained, may be distorted. Such distortion stems from lingering feelings of the client toward therapist. These feelings may range from enduring gratitude to deep resentment. Such feeling states may color and mislead the researcher in the assessment of the client's status. These views suggested the type of study involved will need to rely upon assessment of factual data as a method of reducing distortion which Sargent implies is inevitable.[3] Assessment of data relating to the client must be carefully interpreted and based on discrete data not only from the subject but "ideally

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[1] H.D. Sargent, "Methodological Problems of Follow-Up Studies in Psychoterapy Research," American Journal of Orthopsychiatry, XXX, (May, 1960), 495.

[2] Ibid., pp. 495-496.

[3] Ibid.

from sources other than the patient."[1]

The thirteen studies cited by Gossett and Lewis were related to follow-up from the standpoint of a psychiatric service in a hospital setting. A number of studies relating to follow-up from a child welfare agency have also been located, but were not included in the original survey completed by Gossett and Lewis. Each of these studies will be reviewed for background material relevant to the current study.

Reviewing the thirteen long term follow-up studies, Gossett and Lewis noted several similarities and differences. First, they noted no studies were replicated and, thus, not directly comparable. The subjects came from different hospitals, whose treatment programs dealt with selected patients with a variety of demographic and diagnostic differences. Criteria of change apparently varied from study to study. The similarities of the studies were related to the following factors: first, all thirteen studies examined the adolescents at least six months following discharge. Most were diagnosed as "severe character disorders or psychotics, primarily schizophrenics."[2] All studies included judgments of patient change in terms of improvement from time of admission to time of follow-up and level of function, (i.e., changes in status relative to

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[1]Ibid.

[2]Gossett and others, p. 603.

"normality"). Further, in each study an attempt was made to correlate patient, family, or treatment variables with treatment success.[1] Overall, according to Gossett and Lewis, the studies showed six variables reported to be significantly related to long-term outcome of teen agers who received psychiatric hospital treatment. Three variables concerned the patients themselves, such as the severity of the pathology, the "process-reactive" nature of the psychopathology, and intelligence.[2] Two variables concerned the nature of the hospital treatment program, such as the presence of a specialized adolescent program and the completion of in-hospital treatment. The final factor related to aftercare or the continuation of individual psychotherapy following discharge.[3]

What follows will be a review of each of the studies noted in chronological order. The child welfare studies will be included to cover fully all aspects of the search for background literature.

A review of the literature begins with Potter and Klein (1937). These researchers reported on the outcome of 175 problem children. All children in this study had been out of the hospital (New York State Psychiatric Institute and Hospital) for over one year. Some subjects had been in

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[1] Ibid.

[2] Ibid.

[3] Ibid.

the community for up to three years. The investigators determined the severity of client psychopathology was apparently a highly significant factor in their work. The "situational reaction group" had a positive outcome with 55 out of 97 functioning "successfully". The schizophrenic reaction group had a very poor outcome with only one out of fourteen classified as "successful". The writers concluded that children who have superior intelligence, who have an onset of problems in the prepubertal years--ten to thirteen--who manifest a definite response to treatment during the first six months, and whose parents are free from "neurosis or psychosis" have the better prognosis. Of the total number, 38% had a successful outcome while 62% had an unsatisfactory outcome.[1] A "satisfactory" outcome meant that the child was getting along well at home, in school and in the neighborhood, and was free from symptoms. Anything less was "unsatisfactory".[2] The study concluded the concept of therapy is a sound premise upon which to develop a helping relationship with a troubled child.

The Johnson and Reid study (1947) focused on 339 children who had been treated at the Ryther Child Center in Seattle. This study defined the child as having a

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[1] H.W. Potter and H.R. Klein, "An Evaluation of the Treatment of Problem Children as Determined by a Follow-Up Study," American Journal of Psychiatry, XCIV (June, 1937), 688.

[2] Ibid., p. 682.

successful outcome providing:

> . . . the child, (1) is able to return to his own home or some foster home where he makes a sufficiently good adjustment so that he gives and receives a reasonable degree of satisfaction; (2) is able to get along in public schools or in employment; and (3) is able to accept the codes and mores of the community. Although these criteria . . . exclude subtle measurements of human happiness, they are relatively simple and definable and constitute basic factors in adjustment with which other elements of personal satisfaction unquestionably correlate. . .[1]

The investigators using these criteria computed a success rate of 74.1%. They further subdivided the "successful" children into subcategories and evaluated their progress in treatment. The "unsuccessful" cases were similarly grouped into categories of response to treatment. One of the major conclusions of the study was related to a rather global statement that:

> . . . doubtlessly many factors contribute to a child's emotional illness but only one had a very high correlation with maladjustments in our study of these children, namely, disturbances in family relationships. . .[2]

Johnson and Reid noted that of the sample, 85% of all children included in the study came from homes broken by divorce, separation, death of parents, prison sentences, or mental commitment. In turn, they concluded that such data ". . . would seem to indicate a very high degree of correlation between broken homes and behavior problems . . ."[3]

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[1] L. Johnson and J.H. Reid, "An Evaluation of Ten Years Work with Emotionally Disturbed Children" (Seattle: Ryther Child Center, 1947), p. 4.

[2] Ibid., p. 14.

[3] Ibid.

In terms of this study it is to be noted that a correlation between age at admission and outcome was calculated. The highest positive correlation was for those children admitted between the ages of 1-3 years. These children had a success outcome of 84%; 83% for 4-6 years; 72% for 7-9 years; 73% for 10-12 years; 70% for 13-15 years; 75% for 16-18 years. The researchers concluded that the only "significant difference" in the success of age groups is in the 1-3 and 4-6 year brackets. Overall, they reported excellent results with younger groups of children. The agency reported they could provide considerable psychological and other type support to such children, thereby allowing them to thrive.[1] Although it is not specified, it may be that such children were often placed into permanent foster care. Finally, the study concluded with the view that definitive treatment may help the child reassimilate into a normal community adjustment.

Cameron's (1950) study was a symposium on in-patient treatment of psychotic adolescents. One of the studies concerned admissions to an English hospital setting for a two-year period of time, 1946-1948.[2] All youths admitted were under 18 years of age. Admissions to the hospital were then compared with admissions during the same period

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[1] Ibid., p. 19.

[2] K. Cameron, "Symposium on In Patient Treatment of Psychotic Adolescents," British Journal of Medical Psychology, XX (1950), 110.

of time at another psychiatric hospital unit for adolescents. The total number for both hospitals was 57. The writer then analyzed the ages of admissions and found 75% were 16 years or older; 16% were between 16-14 years; and only 9% were under 14.[1] Each group of dischargees from the hospital was evaluated as "recovered," "relieved" and "not improved". The respective percentages for each group based upon calculations revealed: recovered, 39%; relieved, 36%; and not improved, 12%. These percentages were based upon a population of 41, not 57. The other cases were still in the hospital or were not evaluated as discharges.

Five of the 41 dischargees had returned to the hospital setting, thus 36 subjects had departed, not to return. This study focused entirely on the status of the subject at the exact time of discharge from the adolescent setting and did not utilize any procedures to determine long-range adaptation.

The other significant finding of the Cameron study relates to age. A positive prognostic indicator in terms of course in treatment within the hospital related to age at admission. Generally, Cameron observed that if the youth was 14 years of age or older at admission, outcome was more likely to be successful. Here successful outcome was related to a shortened stay in the hospital

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[1]Ibid., p. 110.

setting.[1] Cameron concluded with the observation that adolescent treatment units should be developed to serve adolescents 14 years of age or older.

Masterson (1956) conducted a long-term follow-up study of 153 children. He used the following adjustment criteria:

1. Level A = Functioning without impairment from symptoms at work or in the home.

2. Level B = Functioning with minimum impairment from symptoms (up to 50%) at work or at home, or functioning at reduced level without symptoms.

3. Level C = Functioning with marked impairment from symptoms (greater than 50%) at work or at home.

4. Level D = Unable to function, hospitalized, or suicided.[2]

Masterson, using these levels, looked at several variables with subjects who had been discharged for a maximum of nineteen years. He found that those clients under 15 years of age at time of admission had a poorer prognosis; above 15, generally a better prognosis. Masterson also found other positive prognostic signs which included a relatively good social adjustment prior to a change in behavior, and rapid improvement without relapse. Negative factors associated with the study included autism, slow improvement during treatment, unimproved at point of

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[1] Ibid., p. 113.

[2] J.F. Masterson, "Prognosis in Adolescent Disorders: Schizophrenia," The Journal of Nervous and Mental Disorders, CXXIV (September, 1956), 221.

discharge, and residential care lasting more than four months. Masterson reported the following variables as unrelated to outcome: sex, family history of emotional illness, and response to psychotherapy.

One of the tables presented in Masterson's study related to re-hospitalization and outcome patterns. He noted that:

> . . . Re-hospitalization appears to be related to poor outcome at a significant level of less than .001. . . . Those who were re-hospitalized were divided into less than three years and three years and over. There is a greater proportion of patients with more than three years in the "D" group than in the "A" group. Analysis showed this relationship to be significant at the .001 level. . .[1]

Put another way, Masterson is saying those with poor outcome would have a tendency to run a greater risk of being "re-hospitalized". No data were presented relative to hospitalization patterns from point of discharge.

Masterson computed outcome percentages by matching diagnosis with adaptation level, i.e., level A through D. His highest level of success was with "psychoneurosis" A or B (the highest levels) 94% while the "schizophrenic" group included 67% for levels C and D.

The next major study was developed by Morris (1956) who studied children between 4-15 years admitted into a psychiatric hospital setting. A total of 90 children were selected for the study. The study focused on the

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[1] Ibid., p. 230.

nonpsychotic, normally intelligent child who was manifesting selected patterns of aggressiveness toward society.[1] The children studied had been admitted over a ten-year period of time, 1925-1935. One of the purposes of the study was to follow the children to maturity in order to assess their subsequent life adjustment. Morris found that of the 90 children, 66 were studied to age 18 years or over. Of these 66, 19% later became psychotic; 21% made a successful adjustment; 59% never made "adequate adjustment".[2] There were two interesting conclusions which Morris made which may have some bearing upon the current study.

First, Morris noted almost all children showed some improvement in their hospital behavior and the majority continued to improve for about one year after they returned home.[3] Adjustment fluctuated markedly until about the 18th or 19th year. Morris noted:

> . . . The adjustment at that age (18 or 19) is a much more accurate reflection of the final outcome. . . . If the child was not adjusting well by the age of 19, he never did. . . .[4]

This is an interesting statement inasmuch as it points to a relative time frame for assessing the impact of

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[1] H.H. Morris, P.J. Escoll and R. Wexler, "Agressive Behavior Disorders of Childhood: A Follow-Up Study," American Journal of Psychiatry, CXII (May, 1956), 991.

[2] Ibid., p. 995.

[3] Ibid., p. 993.

[4] Ibid.

residential treatment. The age component appears predictive. Additionally, the one year adjustment phase is seen for the first time in follow-up literature.

Second, Morris also noted "sexual acting out" (open sex play, either heterosexual or homosexual, open masturbation, and sexual exhibitionism) by the age of 12 years, and inability to adjust to their peers while undergoing the group experience at the hospital were indicative of poor prognosis.[1] This is an interesting conclusion and is not typically studied in relation to successful adaptation.

Errera (1957) studied 59 patients between the ages of 15 and 21 years of age who had been seen in a psychiatric outpatient clinic. The subjects had been functioning in the community after treatment services from 8 to 24 years. The clinical findings of the study were as follows: "good adjustment"--a good work record, (i.e., having one job for at least three years), evidence of community interaction, no bizarre symptomatology, and socially integrated and adapted, 26%; "poor adjustment" had none of "these attributes", and "mediocre adjustment" involved subjects who still had definite limitations. The "mediocre adjustment" rate was 26%; the "poor adjustment" rate was 48%. Errera noted 83% of the entire group had one or more periods of psychiatric hospitalization at some time during the

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[1]Morris, Escoll, and Wexler, op. cit., p. 996.

follow-up period.[1] It was noted the frequency and duration of the hospitalizations were highest in the "poor adjustment" category.

For the "good adjustment" group, Errera noted that "acuteness of onset" may be an important factor in the initial hospitalization. This means a specific traumatic event such as the death of a parent or a spouse had occurred and may have precipitated reaction by the client who, in turn, required services. There was insufficient data to affirm Errera's views on this point, however.[2] In contrast, was the "poor adjustment" group where the "disease had developed insidiously and there was no acute onset".[3] The "mediocre group" presented a very heterogenous profile. The subjects were functioning in society but neither very securely nor very effectively.[4] Errera lumped the "mediocre group" with the "good adjustment" group and arrived at a final overall improvement rate of 52%.[5] The study did generate information relative to hospitalization and did not offer information relative to adaptation failure from point of discharge.

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[1] P. Errera, "A Sixteen Year Follow-Up of Schizophrenic Patients Seen in an Out-Patient Clinic," Archives of Neurological Psychiatry, LXXVIII (1957), 85.

[2] Ibid.

[3] Ibid., p. 86.

[4] Ibid., p. 87.

[5] Ibid.

O'Neal and Robins (1958) reported on an extensive follow-up study involving 526 children who were seen up to 32 years after discharge from a child guidance clinic. The writers located 86% of the subjects. This study compared subjects at follow-up diagnosed as schizophrenic with another group classified as psychiatrically normal.[1] In contrast to the "normal" group, the schizophrenics apparently had a greater number of symptoms and their behavior problems involved more areas of their lives. As O'Neal and Robins note:

> . . . The most striking factor in their histories is that they had more anti-social behavior of many kinds, including physical aggression, incorrigibility, vandalism and pathological lying. They more frequently had difficulties simultaneously at home, at school, and in their social relationships with their siblings and contemporaries. The no-disease group typically had difficulties in fewer areas.[2]

The pervasive nature of the symptoms in the schizophrenic group differentiated them from the normal group but "accentuated the seriousness of their first disturbance". Overall, the comparison of the two groups showed, of those interviewed at follow-up, 10% were diagnosed as schizophrenic while 20% were diagnosed as no disease. Comparison of histories revealed the following information:

1. In childhood the schizophrenic group have more

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[1] P. O'Neal and L.N. Robins, "Childhood Patterns Predictive of Adult Schizophrenia: A 30-Year Follow-Up Study," American Journal of Psychiatry, CXV (November, 1958), 385.

[2] Ibid., p. 390.

symptoms of all kinds than the no-disease group including a large number of anti-social symptoms.

2. More areas of function were disturbed in the pre-schizophrenic child than in the child who in adult life had no psychiatric disease.

3. As adults the schizophrenics have a higher rate of mental hospitalization than the no-disease group.

4. The schizophrenic adults have a higher arrest rate than the no-disease group. The schizophrenics are consequently often treated as criminals rather than mentally ill persons.[1]

Masterson reported in 1958 on a second paper relating to an original follow-up study completed in 1956. Although in his first paper he examined the results with schizophrenic patients, in the later study he examined adjustment patterns relating to the psychoneurotic and psychopathic personality groups. For the psychoneurotic he computed a percentage of success at 94%; (32/34) and psychopathic 11/20 or 55%. These figures were from a total number of 153 adolescents, 12-18 years of age.[2] Masterson found for the lesser disturbed groups the following data were unrelated to outcome: age; length of onset of problems; precipitating factors; abnormal physical findings; family history or emotional illness; social adjustment; length of hospitalization; EEGs; and "neuropathic" traits (early developmental disturbances such as sleep disturbances, nail

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[1]Ibid., p. 391.

[2]J.F. Masterson, "Prognosis in Adolescent Disorders," American Journal of Psychiatry, CXIV (June, 1958), 1102.

biting and enuresis).

Another interesting finding was that response to psychotherapy was apparently unrelated to outcome for both groups.[1] Mixed results occurred with the following variables in terms of outcome. First, with respect to response to treatment, it was observed that rapid improvement without relapse was related to positive outcome in the psychopathic group. In the psychoneurotic group, no relationship between outcome and response to treatment was indicated. Second, in terms of result upon discharge, Masterson observed, as could be expected, that the large majority of psychoneurotics and psychopathics were improved upon discharge, and any patient unimproved at discharge would likely have a poor prognosis. Third, in terms of subsequent success, it was observed that for the psychoneurotic group the great majority were able to continue their lives without "hospitalization or substantial incapacitation". The psychopathic patients varied greatly from recovery to substantial incapacitation.[2]

Hamilton (1961) studied 100 male adolescents with follow-up. The subjects, between the ages of 14 and 18, were admitted into a psychiatric facility in New York over

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[1] Ibid., p. 1101.

[2] Ibid.

a period of ten years.[1] The group represented consecutive admissions from 1946 to 1956. Hamilton found several trends. He observed that stress was an important precipitating factor for hospitalization when linked with background of inadequate personality adjustment dating back many years. He observed "acting out behavior" including stealing, aggressive rebellion against authority, and assaultiveness (particularly toward the mother) was common in both psychopathic and schizophrenic groups which made up 90% of the subjects.[2]

Hamilton believed successful treatment must include not only dynamic oriented psychotherapy but also a broad program directed toward group participation and socialization. A hallmark for males was the opportunity to develop a positive male identification through group experiences. Hamilton further noted successful treatment of the subjects in the psychiatric hospital was a function of the "teachability of the parents" By this Hamilton meant a certain capacity to respond positively to therapeutic intervention. Overall, Hamilton computed a basic success rate of 66%.[3] No definitive criteria were located in the study which were related to "success".

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[1]D.M. Hamilton and others, "Results of Mental Hospital Treatment of Troubled Youth," American Journal of Psychiatry, CXVII (November, 1961), 811.

[2]Ibid., p. 816.

[3]Ibid.

In summarizing the major points of Hamilton's findings, variables relating to success include: a good intellectual endowment, "teachability" of the parents, and availability of a "transitional" phase which Hamilton defines as broad community contacts to "secure" rehabilitation.[1] In terms of negative variables, Hamilton noted early problems with the parents was definitely a negative variable. For example, he noted 90% of the subjects' parents failed to provide harmonious family settings.[2] This was capped with the absence of a father figure which Hamilton felt seriously affected the child's later development. Another related variable was what Hamilton defined as an "immature mother". Such mothers, according to Hamilton, tend to be excessively seductive or simply indulgent with the subjects. He observed the children he studied frequently experienced physically traumatic childhoods culminating with disturbed relationships with peers and others. Thus, another negative variable was related to subject's gradual withdrawal and subsequent failure to mature emotionally and to socialize properly.[3]

Hamilton's assessment of potential for improvement

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[1]Hamilton and others, p. 815.

[2]Ibid., p. 811.

[3]Ibid., p. 812.

was based in part on a sociopsychological view of the child at early infancy or childhood. Such experiences seemed to have a great impact upon the subsequent adjustment of the child.[1]

Overall, Hamilton concluded that the child's strivings for emancipation and movement toward adulthood were important events, and if not handled well by the family could result in subsequent problems for the child. Moreover, youths helped most were those whose families were involved with them in understanding their problems.[2]

Annesley (1961) studies 362 patients admitted to an adolescent unit at St. Ebba's Hospital, England. All subjects were admitted between 1949 and 1954 and followed up for at least two years. For this study Annesley identified four psychiatric diagnostic groups among the youths admitted into the hospital. These included: the behaviorally disordered; the schizophrenic group; the neurotic group; and the affective disordered group. For each of these diagnostic classifications he proceeded to develop tables spelling out in detail information such as recovery rates, outcome and family history, outcome and sex gender, outcome and IQ, and outcome and EEG testing.[3]

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[1]Ibid., p. 811.

[2]Ibid., p. 816.

[3]P.T. Annesley, "Psychiatric Illness in Adolescence: Presentation and Prognosis," Journal of Mental Science, CVII (1961), 269.

For the above diagnostic groups Annesley computed recovery rates. No definition of "recovery" was included in the article, however. Nonetheless, he reported the following recovery rate percentages for each of the groups: behavior disorder, 60%; schizophrenic, 42%; neurotic, 91%; and affective disorders, 93%. These percentages included clients evaluated as not only recovered but also improved in their functioning.

Annesley noted the behaviorally disordered group accounted for half the admissions. The most valuable guide to prognosis was the nature of the symptomatology manifestation. When isolated symptoms occurred, while serious in themselves, they were not as significant prognostically as symptoms which occurred in combination with one another.[1] For instance, he observed when stealing occurred in isolation it was not as prognostic of poor outcome as when stealing was accompanied by another symptom such as pyromania. Other related symptoms in this general area included violence and truancy.[2]

Schizophrenia accounted for 25% of the admission diagnoses. In his study about 20% of the schizophrenic youth recovered or improved compared to about 33% recovery for schizophrenic adults. Again, in terms of the schizophrenic group, neither heredity nor other background

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[1]Ibid., p. 272.

[2]Ibid., p. 278.

data had an influence on outcome. The most prognostic factor was sex gender. Twice as many females as males made a complete remission.[1] Annesley could not differentiate results gained between psychotherapy and chemotherapy. Additionally, he observed the outcome in schizophrenia was typically worse at follow-up which tended to confirm the seriousness of this condition and its poor response to psychotherapy and other forms of intervention.

Neurotic and affective disorders accounted for 25% of the admission diagnoses. Generally both these diagnostic groups responded relatively well to intervention except in those few instances where they apparently had been misdiagnosed.[2]

In summary, Annesley found few prognostic indicators in his study. His strongest statement in terms of prognosis came with respect to multiple symptomatology onset. Insofar as the variables related to the current study are concerned, there are no comparable data except length of hospitalization which was non-prognostic according to Annesley.[3]

Beskind (1962) provided an overview of issues and concerns dealing with the in-patient treatment of adoles-

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[1]Ibid.

[2]Ibid.

[3]Ibid., p. 271.

cents in both hospitals and non-hospital settings. He has not completed a long-term follow-up study as such but what he accomplished was to bring into focus a number of the concerns around disordered youths placed away from home.

Much of his paper is concerned with a primary issue of the day, whether to place the disturbed adolescent with peers or to place him/her in an adult ward. The pros and cons of the practice were reviewed by Beskind in some detail. He concluded that the "adolescent-adult wards with the development of specific programs offer a more positive therapeutic or management approach to these same problems". . . .[1] He suggested the reasons for establishing adolescent-adult wards center around the ego, supportive, control and integrative functions that adult figures might have. With this issue resolved for Beskind, he then moved to an examination of clinical experience in dealing with adolescents on an in-patient basis.

Beskind reviewed the Carter, Masterson and Annesley study and noted "striking similarities between the three reports". First, he noted reports of improvement at discharge were quite different from long-term follow-up with respect to the schizophrenic disorders. The major implication for Beskind from this statement is that

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[1]H. Beskind, "Psychiatric Inpatient Treatment of Adolescents A Review of Clinical Experience," Comprehensive Psychiatry, III (December, 1962), 359.

researchers must question carefully discharge or short-term follow-up results if used as the sole criterion of therapeutic effectiveness of residential or in-patient care. Beskind further noted there is little evidence of deterioration in the follow-up results for the affective disorders, psychoneurosis or psychopathic disturbances.[1] He noted further:

> . . . A survey of discharge results from other adolescent treatment units reveals that most authors have the same experience. Generally, 65-75 per cent of patients show symptomatic improvement at time of discharge regardless of diagnostic category or therapeutic approach. . . .[2]

Second, Beskind focused on the similarity of follow-up results when he suggested "that the differential effect of various treatment modalities was not critical in the long-term course of the illness. . . .[3] This is an interesting conclusion for Beskind inasmuch as the three reports he studied represent different treatment approaches ranging through custodial care, physical therapy, to intensive psychotherapy. Beskind noted the sparsity of systematic investigation into the problems of treatment of adolescents in inpatient settings.[4] His view of the relative similarity of follow-up results regardless of diagnostic category may reflect a basic lack of assessment

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[1]Ibid., p. 365.

[2]Ibid.

[3]Ibid., p. 366.

[4]Ibid., p. 367.

of the relevance of items which constitute the treatment of children.

Weiss and Glasser (1965) reported a study of the social adjustment of adolescents discharged from a mental hospital which specifically treated mental disorders of adolescents. They proceeded to study a group of 55 adolescents all of whom were discharged within a relatively short time, six months, from the setting. The group was about equally divided between males and females. Specifically, the report attempted to survey in detail the transition of the adolescents from the hospital to their home community. The researchers set out to secure answers to a number of specific questions they had encountered in their clinical experience with the clients.[1]

The questions raised by the researchers included the following. Is there a correlation between length of hospital stay and transitional adjustment? Were those youths discharged from the Day Treatment Program or the Day Hospital Program able to make a smoother community adjustment compared to those youth coming from the hospital's adolescent unit? Did adolescents whose parents received continuing support from the hospital staff after their children were discharged fare better during transition than those whose parents did not seek aid? Is the type of

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[1]T. Weiss and B. Glasser, "Social Adjustment of Adolescents Discharged from a Mental Hospital," Mental Hygiene, XLIX (1965), 378-379.

illness, as manifested by onset, duration, and ward behavior meaningful in terms of predicting post-hospital adjustment? And finally, what issues are involved in maintaining the continuation of growth and revitalization outside of the hospital setting?[1]

The investigators set out to find the answers to these questions through obtaining post-discharge information from contact with an adult member of the child's family. For this study they defined "transition" as the period of time between six to twelve months following discharge from the center.

Weiss and Glasser studied length of hospital stay, whether the subject was discharged from the Day Treatment Program or Day Hospital, with adjustment process during the transition. The investigators were not able to determine a significant correlation on any of the noted variables with adjustment process during the transition.[2]

Insofar as continuation of psychiatric treatment was concerned, less than half of the total group discharged were involved in further treatment following discharge. This included any type of treatment. This is a significant finding because:

> . . . for the most part, parents felt that their problems with their children remained unchanged. . . . They reported difficulties in the general area of

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[1]Ibid., p. 379.

[2]Ibid., p. 381.

> adjusting to the patient's presence and concern with his or her mental stability. . . . The majority of the relatives interviewed felt that the patient had not been able to adjust to family life during the transition. . . .[1]

Thus, although parents apparently were concerned about the child, they were hesitant to seek further treatment.

The researchers then looked at the onset of the child's "illness" and attempted to prognosticate adjustment success for the subject. They found those youth who experienced symptoms during adolescence or who became symptomatic through an insidious development of the symptoms were less likely to fare well during the transition phase.[2]

Weiss and Glasser also found discharge status was not likely to prove predictive. For instance, although 65% of the total group discharged were evaluated as "improved" only one such subject could be rated as having made a good "social" adjustment. Overall, they concluded over thirty of the fifty were improved compared to their pre-hospitalization status.[3]

Another conclusion of these investigators was to recommend some type of an innovative after-care program that

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[1]Ibid., p. 382.

[2]Underlined as in the original text. Insidious process is contrasted by Weiss and Glasser with what they define as acute onset. Youths then who became symptomatic during adolescence with an acute onset fared better during the transition.

[3]Weiss and Glasser, p. 382.

would attempt to deal with the parents' concerns relative to their coping skills when the child returned home. This recommendation was made due to the striking absence of parental involvement in treatment activity.[1]

This study did test a number of questions which pertain to the current study especially length of care, prediction at discharge, and the concept of "transition". Although length of care is directly comparable, the concept of prediction at discharge is dissimilar inasmuch as a formal instrument was not employed in the Weiss and Glasser study. The concept of a "transition stage back to the community" is viewed as an attempt to focus in on the discharge time of adjustment for the child.

Warren (1965) reported the results of a follow-up study involving 157 subjects. The follow-up included subjects discharged up to six years. In this study Warren examined a number of variables and related them to the discharge course. His findings suggested there was no correlation between outcome and length of pre-admission "illness", socioeconomic status of the family, physique, maturity nor level of intelligence (except for what he describes as "sub-normals"). For those who had been diagnosed as having a psychotic disorder and other severe disturbances, they tended to have a poorer outcome than what Warren described as the neurotic and mixed neurotic groups. Put another way,

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[1]Ibid., p. 384.

those who were less disturbed tended to have a better prognosis.[1] Those, however, who were still seriously disturbed at discharge tended to remain quite disturbed at follow-up. Warren noted the prognoses made at discharge showed numerous disparities and generally:

> . . . they tended to be too pessimistic for the neurotic disorders groups, but in the psychotic disorders group most cases did badly, regardless of the prognosis given. . . .[2]

Warren was able to identify age as a significant factor in outcome. Those subjects under 14 1/2 years at admission did significantly better than subjects above that age.[3] He was also able to report for the less disturbed groups (neurotic disorders) the females as a whole did better than males at outcome. The difference in proportion for this group was significant but not significant for other groups.[4]

This particular follow-up report had an interesting format for reporting on the follow-up period with subjects. A "Record of Psychiatric Illness During Follow Up Period" was developed which listed diagnostic categories with two other variables: severity (of illness) and continuity. The

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[1] W. Warren, "A Study of Adolescent Psychiatric In-Patients and the Outcome Six or More Years Later: II The Follow-Up Study," Journal of Child Psychology and Psychiatry, VI (1965), 159.

[2] Ibid.

[3] Ibid., p. 154.

[4] Ibid.

"continuity" variable was, in turn, broken down into time-frames specifying the onset of the "illness" from point of discharge. For example, the author had the variable broken down into "early", "intermittent", "continuous" and "unknown". Warren then examined cases at follow-up and placed the subject into a respective category. He then proceeded to report the percentages of each diagnostic category which fell into the different classifications. For instance, with psychotic disorders, 89% had serious illness during the follow-up period and with 75%, it was continuous.[1] This format represents an attempt to identify with respect to time from discharge the onset of further interpersonal problems for the subjects. Specifically, it focuses upon the nature of the subjects' "symptomatology" and its duration and intensity.

Overall, Warren computed a 68% success rate for the neurotic group, 54% for the mixed conduct and neurotic group, 44% for conduct disorders and 26% for psychotic and other disorders.[2] These percentages were for his classes A and B defined respectively as "requiring no psychiatric treatment and no anti-social record" and Grade B, "requiring treatment from a non-specialist and/or court appearance or probation only". Both of these classes were the highest

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[1] Ibid., p. 143.

[2] Ibid., p. 149.

adjustment classes for this study.[1]

Beavers and Blumberg (1968) reported a follow-up study involving 47 subjects discharged between September, 1960, and May, 1966, from an adolescent unit at a psychiatric hospital setting. All subjects were under 19 years of age during their hospitalization. All had been in the hospital for at least ninety days. The average time between the discharge date and follow-up was 29 1/2 months. All subjects had been discharged between 1-5 years.[2] Beavers and Blumberg noted a rationale for their research was to improve treatment of adolescents:

> . . . The usual way of improving treatment methods is to measure treatment results and relate methods used to these results. In the case of adolescent treatment this is extremely difficult. . . because no one treatment method is used exclusively. . . .[3]

They reached several conclusions in this study. First, their hospital moved from treatment of organic and chronic schizophrenics to acute schizophrenics and character disorders. Second, the psychotic adolescent stayed in the hospital somewhat longer than the lesser disturbed adolescent (non-psychotic). Third, there were no further hospitalizations for the non-psychotic subjects, but almost half (12 of 26) of the psychotic patients had been rehos-

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[1]Ibid., p. 148.

[2]W.R. Beavers and S. Blumberg, "A Follow-Up Study of Adolescents Treated in an In-Patient Setting," Disordered Nervous System, XXIX (September, 1968), 606-607.

[3]Ibid., p. 606.

pitalized during the follow-up period. No data were located which identified time from discharge for the noted hospitalizations. Fourth, individual treatment following discharge appears to be positively correlated with good results in the "acute" schizophrenics and in the "behavior disorders", with 80% of these patients improved. The researchers were impressed with the relationship of these variables and noted that, in part, the high positive relationship may be attributed to the uniqueness of their setting wherein psychiatric residents would follow the subjects after discharge. Apparently the high degree of continuity and message of care and concern was helpful for the former patients.[1] Next, the reasonably good results with the acute schizophrenic group and the character disorder group encouraged the authors to believe the hospital environment can definitely assist in ego building for subjects and stimulate a positive social rehabilitative process.

With the schizophrenic group of subjects the investigators reported an improvement rate of 62%. With the character disorder group they reported an improvement rate of 69%.[2] They observed that, based on their experience and comparison of their results with other follow-up studies,:

> . . . The data presented. . . offer some tentative support for the concept that better results are obtained in a hospital unit which has a specific program for

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[1] Ibid., p. 609.

[2] Ibid.

> adolescents and that the usual high staff-patient ratio found in such units is effective in producing a greater percentage of favorable results than treatment without such a specialized program. . . .[1]

The above statement was made by the investigators after statistical tests of significance were made on the different outcome results from a number of prior follow-up studies.

Allerhand, Weber, and Haug (1966), focused upon a group of fifty boys who had been at Bellefaire during a three and one-half year period, 1958-1961. All subjects had been in residence at least six months. The follow-up took place two years after discharge when they were, on the average, about 18 years of age.

They set about to describe the "fate" of these boys at the time of follow-up. The design of the study included obtaining data at four points in time: at three intervals during the institutional stay, three months, fifteen months, at discharge and finally, at the follow-up two years later.

All but a few children made some role progress. Age made a difference in terms of institutional adjustment.[2] Younger children at admission were more likely to show consistent change toward adequacy than older ones. Progress was not unified and the researchers observed that the area

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[1]Ibid., p. 610.

[2]M.E. Allerhand and R.E. Weber, Adaptation and Adaptability: The Bellefaire Follow-Up Study (New York: Child Welfare League of American, 1966), p. 3.

of least progress was with the peer group and school.[1] Additionally, the progress observed was not constant and some regressions occurred.

Although the study indicated that generally the boys were functioning well at Bellefaire, these measures of functioning were not solid indicators of their functioning after discharge:

> Perhaps the most striking finding of the study is that none of the measurements within Bellefaire of performance at discharge, either in the casework or in cottage and school roles, were useful in themselves in predicting postdischarge adaptability and adaptation.[2]

The researchers found that in a stressful community situation the gains during the institutionalization tended to break down, whereas in a supportive situation, these strengths tended to be shored up.

Allerhand and associates identified several findings from their study. First, the youths who entered before the age 13 evidenced the greatest growth in areas of adequate performance in school, cottage and in the relationships with adults, peers and tasks. In part, they thought the growth might be related to the more serious disturbance patterns of younger children who were institutionalized.[3]

Second, most boys with high potential at admission displayed adequate role performance in all areas by the time

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[1] Ibid., p. 140.

[2] Ibid., p. 138.

[3] Ibid.

of discharge. Many with lower potential were able to adapt to the institution and make gains particularly with respect to the cottage and interpersonal relations with adults.[1]

Third, growth was not constant and there were wide swings in performance.

Fourth, the youths tended to adapt more successfully to the cottage and less well to school settings. The researchers believed this was related to the differences in structure and space. That is, they did less well in school, which is more bound "by the norms of society".[2]

Next, the investigators concluded that an internally-oriented approach to the child's problems is inadequate. They recommended the community be brought into the institution. The objective here was to increase the social demands upon the child through accelerated exposure to community experiences. This included not only such services when the child was in the institution but aftercare service as well. Aftercare services were strongly recommended.[3]

Allerhand et al. found the length of institutional care was not significantly related to the adequacy of post-institutional adaptation. Thus, the child who stayed longer did not necessarily develop more adequate adaptation. They point out the presence of the child in the institution

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[1] Ibid.

[2] Ibid., p. 139.

[3] Ibid., p. 148.

should be viewed as an enabling step "to the external environment", not as a "program designed to make the child learn how to live" within the setting.[1]

Overall, the authors computed a 74% level of success based upon adaptation to the community (37/50). The concept of adaptation was extensively defined and developed for purposes of this study. They evaluated 57% (28/50) in their adaptability (a "state of readiness to meet demands on a selective basis").[2]

King and Pittman (1969) reported on a follow-up study involving 65 subjects admitted to a psychiatric hospital setting between July, 1959, and June, 1960. These youths were then contacted in 1966 and 1967 to determine their current status.

The central focus of this study was to utilize a sophisticated approach to compare initial diagnostic statements regarding clients with later diagnostic statements made at the time of the actual follow-up. One of the investigators, a psychiatrist, made initial psychiatric diagnostic statements regarding the subjects, and the second investigator, also a psychiatrist, proceeded to make diagnoses of the clients at the time of follow-up. Generally, psychiatric interviews were utilized for the second diagnosis.

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[1] Ibid., p. 145.

[2] Ibid., p. 115.

Actual follow-up interviews were obtained in 56 or 86% of the cases.[1]

The process involved the "follow-up" psychiatrist not seeing the former patient's charts nor knowing anything about the initial diagnosis. A list of descriptive items for various diagnostic categories had been developed by the researchers and was published with their article. The list of criteria were used in the follow-up diagnostic procedure.[2]

Another procedure was to provide "typological" diagnoses for each of the former subjects. The typology was, in effect, a broader band of psychiatric symptomatology. For instance, they classified all subjects into four specific groups: psychotic, behavior disorder, neurotic and undertermined.[3] From this classification, the second psychiatrist was able to predict 40 or about 67% similarity.[4] The rationale for utilizing the typology diagnosis procedure was clarified as follows:

> These diagnoses (typological) provided a different perspective for assessment of presenting a clinical picture which could be evaluated for prognostic value and made possible comparison with other studies using

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[1] L. King and G.D. Pittman, "A Six Year Follow-Up study of 65 Adolescent Patients: Predictive Value of Presenting Clinical Picture," British Journal of Psychiatry, CXV (1969), 1437.

[2] Ibid., p. 1140.

[3] Ibid., p. 1438.

[4] Ibid., p. 1440.

similar categories.[1]

Apparently the percentage was not higher, though one would expect this due to the more restricted categories and changing symptomatology for some patients.[2]

Another component of the study was to utilize the diagnoses offered as "prediction of recovery". Based upon the criteria for describing criteria for diagnoses spelled out in the study, the investigators arrived at a predictive factor of 79%. This meant they were able to predict recovery or chronicity in the follow-up group at this percentage. This statement was made only for the diagnostic procedures not for the "typological" process.[3] Thus, they conclude the diagnostic categories for this study as applied to this group of subjects proved stable and predictive of the future status of the subjects.

Hartman, Glasser and Herrera (1969) reported on a follow-up study involving 55 subjects hospitalized for mental illness during adolescence and then evaluated five years after discharge. The group of 55 adolescents studied represented the consecutive admissions to a mental health hospital (1959-1961). The subjects were between 14-17 years of age. All were white; they were evenly divided as to sex. About 50% were middle or upper class, and half

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[1]Ibid., p. 1438.

[2]Ibid., p. 1440.

[3]Ibid.

were lower class. Twenty-four were diagnosed schizophrenic at admission; the others received a wide variety of different diagnoses.[1] It is interesting to note that this was one of the few follow-up studies reviewed thus far where emphasis was made on working with the child's family.

> All families were interviewed by social workers; in over half the cases the mother, and occasionally, the father, met regularly with a social worker throughout the patient's stay in the hospital.[2]

At the time of follow-up, a written description of each subject's situation and status was made as well as analysis of the following areas: family relationships, peer relationships, and school and work. Additionally, the subject was also rated as to overall adjustment and change (improvement). A researcher proceeded to contact the subjects or parents, relatives and other sources.

In terms of findings, the researchers began by noting the group as a whole at follow-up averaged 22 1/2 years of age. Over 50% of the group had one or more mental hospital readmissions and the investigators noted those that did not have a rehospitalization[3] "appeared to be using their homes as small psychiatric institutions and their family members as caretakers".[4]

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[1] E.Hartman, B. Glasser and L. Herrera, "Adolescent In-Patients: Five Years Later," Seminars in Psychology, I (February, 1969), 66.

[2] Ibid., p. 67.

[3] Ibid., p. 68.

[4] Ibid.

The researchers then turned to the question of prognosis. They proceeded to utilize 60 demographic variables describing each patient before admission, 16 variables describing the character of the illness and 38 variables describing the patient's hospital course and treatment. Each of these variables was related to the outcome at follow-up. At the time of the follow-up ratings of good, fair, poor, improved, no change, or worse were ascribed for each former patient.

The authors then examined prognostic factors for the group of subjects. Almost none of the "history" or "pre-hospital" variables was able to predict outcome. There were a number of variables the authors described as "weakly related to outcome"[1] which included "full sibling order: oldest (-)". That is to say, a negative correlation related to outcome. "Leadership in peer groups: rarely or never (-)," and "history of enuresis (bedwetting) (-)" and "psycho-therapy before hospitalization: none (+);" "psychotherapy over eighteen months (-)." It is interesting to note that variables "unrelated to outcome", either positively or negatively, included "age at hospitalization", and "family

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[1] "Weakly related to outcome" implies a trend of relationships in the same direction with the outcome variables, with several X^2 results significant at $p < .05$. "Definitely related" implies a stronger trend of relationships in the same direction, usually with two of the five X^2 results significant at $p < .05$. (+) means related to good outcome. (-) means related to poor outcome (p. 71 of the Hartman, Glasser, and Herrera study).

relationships".[1]

Only a few of the "inhospital" variables showed definite relationships. These variables included: "precipitating event; clearcut external event (+);" "confused on admission: no (+);" "defense against infantile objectives: regression(-)." The last variable was carefully defined by the authors to mean that those adolescents who regressed to earlier childhood patterns or who generally refused or were unable to give up infantile ties to the parents generally could be expected to be associated with a negative outcome. Another variable definitely related to outcome was "length of stay: over 18 months (-)". The investigators indicated that those youth requiring care over that period of time were probably more acutely disturbed and thus, the prognosis over the long haul would be more pessimistic.[2]

"Weakly related to outcome" included "therapist-administrator split: no split (+)", "group therapy: 21 or more meetings (+)," "duration of drug therapy: no drug therapy (+)," and "mother and father seeing social worker together: no (+)." The last finding is surprising as it suggests that when the parents are not being seen together a more positive outcome is effected at follow-up.

Still related to in-hospital variables and "not

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[1]Hartman, Glasser and Herrera, p. 70.

[2]Ibid., pp. 73-74.

related to outcome" are the following variables: "longest stay on the ward", "discharged where," and "therapy after discharge". It is interesting to observe that variables relating to parental participation in therapy were "unrelated to outcome:" "father in group therapy," "mother in group therapy," "mother and father in same group," "father's visits with social worker," and "mother's visits with social worker". The variable "frequency of family visits" was tested with this study and was also unrelated to outcome.[1]

The investigators observed that among the many psychotherapy variables tested, only length of group therapy was definitely related to outcome. In the hospital setting the group therapy procedure was optional. Thus, the authors speculated that those who would enroll for group therapy may have been doing relatively well anyway on the ward and comprised a higher functioning group of subjects. Generally, however, they believed that further exploration of this area would be important since they tended to believe group therapy was uniquely useful in enabling adolescents to discover the universality of some of "their more frightening feelings and impulses".[2]

Another variable that received considerable discussion

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[1]Ibid., p. 73.

[2]Ibid., p. 74.

in the paper concerned the "pre-hospital" variable describing activity in peer groups before admission. The variable was "weakly related to outcome". However, the researchers noted that subjects rated as being "at least a sometimes leader" in peer relations before admission, usually at ages 10-15 years, were still functioning best in the social area at ages 22-23. They noted this finding contrasts sharply with the findings in other areas of functioning, in overall functioning and in "change" ratings, all of which tended to show great variability over the years. They concluded that constant factors involved in the ability to establish peer relationships may be developed as early as puberty and may tend to change very little even through the storms of adolescence.[1]

These researchers were profoundly moved by the findings. They clearly felt an overall pessimism that was not related to the final ratings but which concerned the feelings of despair and hopelessness which they picked up through subject contacts. The final ratings for the study in terms of "overall level of functioning" were "good: 12 (25%), fair: 19 (40%), poor: 16 (35%)". The total number was 47.[2] One of the interesting observations made concerns the area of family relationships. They observe that the group as a whole apparently was doing best in terms of

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[1]Ibid.

[2]Ibid., p. 69.

"family relationships" at follow-up. They observe that:

> The interview material makes it clear that much severe pathology was masked in this area (of family relationships) since the family, unlike most other institutions of society, is able to adapt to the patient rather than demanding adaptation from him.[1]

In the cases cited by the investigators, it is apparent the families had adjusted to the odd hours, strange life patterns and "restricting symptoms" of the youths after they returned home. Nevertheless, apparently the families saw some improvement.

In their final comments regarding the study, the researchers thought that their treatment program would require modification to include further services to the adolescent to smooth transition discharge to the community. However, they concluded by writing that notwithstanding a number of changes that could be made to their program, they were pessimistic about adolescent treatment. They noted their treatment program was only marginally successful even though it was using the most modern methods of treatment and was adequately funded. They observed that perhaps most adolescents sufficiently disturbed to require psychiatric hospitalization, even though they may appear relatively healthy in ways, may have undergone damage "too deep to be greatly altered by any of the methods currently at our disposal".[2]

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[1] Ibid., p. 75.

[2] Ibid.

Levy (1969) completed a follow-up study of 100 children and adolescents treated in a residential treatment setting. He proceeded to follow up on the subjects who were at the Menninger Foundation's Southard School between the years 1945-1960. A total of 113 subjects was discharged, and Levy was able to make contact with 100. He was able to report an 88.5% follow-up. Of the total 113 patients discharged there were 83 boys and 30 girls. At admission their ages ranged from 5 to 15 years.[1] Most of the children admitted were experiencing severe emotional disturbances.

Contact was made by telephone and letter. The investigator noted use of the telephone for follow-up studies was desirable because of "the depth of the interview and the sense of validity attainable in a telephone contact". Levy proceeded to contact the former subjects, relatives and/or families for data.

One of the unusual components of this study was the survey of "subject's life patterns". Of the 100, about 34% are living lives which the author describes as "ordinary", such as married well, regularly employed, professionally trained, responsible, and content.

Another 24% seem to have made marginal adjustment along these lines. Seven patients, although apparently able to function independently, are more "actively peculiar".

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[1]E.Z. Levy, "Long-Term Follow-Up of Former In-Patients at the Children's Hospital of the Menninger Clinic," American Journal of Psychiatry, CXXV (June, 1969), 1633.

Six were still seriously ill following their discharge, yet made a change for the better. Eleven were chronically ill. Ten were in psychiatric institutions; three in penal settings, and five are deceased.[1]

Regarding the group's educational attainments, there are two Ph.D.'s, three M.D.'s, nine M.S. degrees, 19 bachelor degrees. About eight were in high school, and another 20 were in college. Insofar as marital status was concerned, 25 were happily married, seven unhappily married, 12 divorced, five married twice, five married three or more times, and 45 apparently never married.[2]

In terms of careers, there were sixteen professionals, eleven white-collar workers, and thirteen housewives. About 60 of the 100 were labeled self-supporting. Eight had poor work histories, and eight never really worked.[3]

Sixteen subjects had IQs below 90. For those with IQs below 90 only four of these subjects ever achieved ordinary or marginal adjustment. The IQs of most of the chronically ill patients were low also.[4]

In terms of psychological outcomes for the group, the researcher thought that in general, outcome seemed to follow the "prognostic implications of the original diag-

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[1] Ibid., p. 1636.

[2] Ibid.

[3] Ibid.

[4] Ibid.

nostic statements". For instance, those patients originally diagnosed as schizophrenic or experiencing a psychotic reaction of childhood, especially those with low IQs, tended not to do well as could be predicted from the diagnosis. The exceptions to this statement appeared to be those subjects who did not seem so seriously disturbed.

Levy attempted to integrate the characteristics of the subject who was most likely to do well. He classified this patient as the person who was attractive, likeable (to someone), intelligent, verbally facile, unaggressive, and possessed a "good patient" profile.[1]

He identified 28 patients as having completed treatment. Of this group, 85% were in the ordinary or marginal adjustment groups. Another 30 patients were terminated due to "institutional reasons". Examples of such discontinuance would include overt aggressiveness and lack of response to treatment procedures. Of the group terminated for "institutional reasons", only 33% were in the ordinary of marginal adjustment classification. Families terminated the treatment of 25 patients, and of this group, 58% were in the ordinary or marginally adjusted category. Another 17 subjects were short-term cases whose ultimate adjustment patterns were apparently comparable to the long-term cases.[2]

Levy believed overall about half the patients were

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[1] Ibid., p. 1637.

[2] Ibid.

helped by removing them from a destructive situation to a more benign situation. Further, he felt counseling or psychotherapy procedures were helpful to that group of patients who needed the structured qualities of the hospital the least. The follow-up indicated few of the subjects reported their psychotherapy as the one thing they felt helped most. A critic reviewing the Levy article observed this stance from former child patients was not unusual inasmuch as the frustrations of the therapy experience often overshadow the feeling of relief at being understood for some time.[1]

Levy concluded that the agency was able to obtain follow-up data on former residents easily through using telephone contacts. He cited the value of the follow-up procedure as helpful to staff in assessing impact of program.

Garber (1972) studied 120 adolescents and set out the following objectives for his study.

1. To determine the adolescent population and its hospital course.

2. To determine what has happened to former adolescent patients and the status of their functioning.

3. To get some idea of their reaction and utilization of the hospital and the adolescent program.

4. To extract variables from the hospital stay they

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[1]Ibid., p. 1639.

would relate to current functioning.[1]

Insofar as the methodology of the study was concerned, the researcher reviewed adolescent records and abstracted data on a questionnaire form. This specific study involved an interview with former residents of the adolescent unit. In contrast to the Levy study, it was observed that significant difficulty was encountered in attempting to locate former patients.[2] Nineteen scales were developed by the author which were designed to measure all areas of current functioning and hospital stay. An example of such a scale would be as follows: "employment: degree of employment stability--very high to insufficient information."[3] All subjects at the time of the follow-up interview had been discharged from 1 to 10 years.

In analyzing objective number 1 of the study, the investigator complied a profile of the typical patient at the hospital. Generally, they described the typical patient as being a 15 year old youngster, usually Jewish, upper middle class, intact family, an only child or one of a sibship of two, lengthy history of previous psychotherapy, symptoms usually outward directed and brought to the

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[1]B. Garber, Follow-Up Study of Hospitalized Adolescents (New York: Bruner and Mazel 1972) pp. 11.

[2]Ibid., p. 53.

[3]Ibid., p. 59.

hospital directly from home.[1]

Male and female patients were compared. The distribution by diagnostic categories revealed the male adolescent was more disturbed on admission. Of the psychotic group, 66% were male whereas only 33% of the neurotic group were males. In studying "condition at discharge", 90% of the unimproved category were boys. From the examination of variables in relation to condition at discharge the study proceeded to draw contrasting profiles between the unimproved and markedly improved group. The unimproved profile is described by the following characteristics: 1. male; 2. length of stay less than six months; 3. use of some type of medications; and 4. lack of involvement with other adolescents, staff and program. The markedly improved profile is described by: 1. length of stay six to twelve months; 2. use of medication--infrequent; 3. two-thirds probability that the parents would be in treatment; and 4. marked involvement with staff, program, and other adolescents.[2]

Insofar as objective 2, current functioning, the researchers divided the follow-up group into three divisions: the high functioning group; the moderate functioning group; and the low functioning group. Each of these areas was determined by the number of points the patients would

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[1] Ibid., p. 79.

[2] Ibid., p. 80.

accumulate from the 19 subscales. Of the group studied, it was determined that 45 subjects were in the "higher functioning group", or 39%; the "moderate functioning group" included 46 former patients or 40%; and the "low functioning group" included 24 subjects or 21% of the total group. In combining the higher functioning group with the moderate functioning group, a total percentage of 79% is computed for adolescents who were able to function in the community.[1]

"Rehospitalization" patterns were also studied for the group. The researcher noted a surprisingly large number of former patients, 38% needed to be rehospitalized. The rehospitalized adolescent group was divided into three units based on length of hospitalization. Short term hospitalization was less than three months and included 12 patients (a final number of 115). Moderate length hospitalization was three through twelve months. This group included the largest group, twenty patients. Long-term hospitalization was over twelve months. Twelve patients were in this group. It was observed by Garber that there was a relationship between the length of rehospitalization and the frequency of hospitalization. Most of the short-term and moderate length rehospitalizations entered the hospital only once. Most of the long-term rehospitalizations had been in the hospital more than once.[2] Although fairly detailed re-

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[1] Ibid., p. 107.

[2] Ibid., pp. 101-102.

hospitalization patterns were included within this study, no information was included which detailed the onset or rehospitalization for various subjects.

In terms of objective 3 of the study, "to get some idea of their reaction and utilization of the hospital and adolescent program", data were obtained through a section of the questionnaire dealing with the subjects views of the hospital experience. Ninety-three of the 115 respondents felt they had a positive experience in the hospital.[1] This area was further broken down into an analysis of several subcomponents of the hospital experience. For instance, "reaction to therapist", "reaction to nursing care", "reaction to adjunctive therapy", "reaction to school", and "reaction to management of day-to-day behavior". The findings related to these variables are respectively: most of the subjects, 67%, felt they had a high positive relationship with their therapist; about 80% had a high positive experience with the nursing staff. The patients rated high positive 56% in their responses to adjunctive therapy activities. The most negative response was in relation to the school. Only 48% of the respondents had a high positive response. Garber thought the school had a rather low positive response from the adolescents inasmuch as many of the youngsters had encountered difficulties in school before admission. In terms of "reaction to management of day-to-day behavior",

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[1] Ibid., p. 119.

the area dealing with structure of the unit, rules and regulations, 60% of the respondents rated this area as high positive.[1]

The final area of the study related "to the extraction of variables from the hospital stay that would relate to the current functioning" of the subject. There were eight variables selected which were found to be correlated at less than the .10 level. The variables were: length of stay in the hospital; private and service status; discharge diagnosis; condition on discharge; optimism of the staff; involvement with the adolescent group; medication in the hospital; and involvement and interest of the staff. Discharge diagnosis and involvement with the staff were found to be significant at the $p<.05$.[2] Overall, Garber felt the two best predictors of functioning at follow-up were medication in the hospital and involvement and interest of the staff. Garber felt these two variables were critical as the hospital staff would not prescribe medication unless it were "a last resort". Thus, if a child received medication in the hospital, it was typically a sign of behavioral chronicity. Insofar as the involvement and interest of the staff are concerned, Garber tended to view this as a recurrent finding with clinicians. That is,

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[1]Ibid., pp. 120-128.

[2]Garber, pp. 154-155.

the involvement of the staff with a patient is usually seen as a "transactional process" contributed to by both patient and staff.[1]

Taylor and Alpert (1973) reported a follow-up study with these objectives:

1. To assess how children were adapting after treatment.

2. To examine discharge plans for the degree to which they were specified.

3. To assess the degree to which postdischarge environments were supportive or stressful.

4. To attempt to understand the relationship between postdischarge environments and treatment.

5. To explore the reasons some children did not respond to postdischarge service.[2]

The 186 children selected for the study had been in a residential program (Children's Village, Conn.) for six months or longer. Of the 186, 75, or 40%, made up the final sample. In order to assess the children a modification of the Rosen-Burns Community Adaptation Scale was utilized. Measurement of change during treatment was made. Further, assessment of community support following treatment was undertaken. The investigators then proceeded to test four hypotheses for the study:

1. The greater the degree of continuity in post-

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[1] Ibid., p. 155.

[2] D. Taylor and S. Alpert, Continuity and Support Following Residential Treatment (New York: Child Welfare League of American, 1973), p. 50.

discharge environment, the greater the degree of the child's adaptation to the environment.

2. The greater the degree of support in the postdischarge environment, the greater the degree of the child's adaptation to the environment.

3. The greater the degree of preadmission adaptation, the greater the degree of postdischarge adaptation.

4. The greater the degree of adaptation gained in the institution, the greater the degree of postdischarge adaptation.[1]

From their study Taylor and Alpert determined the factors most significantly associated with postdischarge adaptation: the child's perception of family support after discharge, and other factors which may be interpreted as continuity of family support before, during, and after discharge. Such "other factors" included early detection of the problem, contact with professional helping agencies before admission, parental visiting and involvement in treatment during care, and continuity of living arrangements after discharge from care. Their findings supported Hypotheses 1 and 2.[2]

Hypothesis 3 was not supported by the study. As measured by the Community Adaptation Schedule, the findings suggested it is not possible to predict a "child's postdischarge adaptation on the basis of a given set of preadmission characteristics". Although preadmission

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[1] Ibid., p. 51.

[2] Ibid., p. 50.

characteristics were not related to outcome, there were four characteristics that did show a positive relationship to subsequent adjustment. These included--children whose problems were not long-standing, children who were young, children whose family situation had stabilized, and children who had some prior knowledge of a helping relationship. Such children achieved a higher level of adaptation in their postdischarge environment than children to whom these factors did not apply.[1]

Hypothesis 4--the degree of change children achieved in residential treatment--was not significantly related to postdischarge adaptation. Children who attended on-grounds school showed a significantly higher level of adaptation after discharge, but those who only continued in therapy after discharge showed a significantly lower level of adaptation. The investigators suggested that family involvement had an overall positive impact on adaptation:

> The researchers feel that the findings of this study indicate that increased work with families as a unit is appropriate, and even greater emphasis should be placed in this direction.[2]

The next study reviewed was that of Davids and Salvatore (1976). This study focused upon children at the Emma Pendelton Bradley Hospital from 1953-1959. These

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[1]Ibid., p. 51.

[2]Taylor, p. 51.

researchers described the philosophical background of the hospital which appeared to be essentially psychoanalytic with little effort devoted to changing symptoms.

A group of 325 patients admitted to the hospital between August, 1953, and July, 1969, was the sample. From this group, only 79 questionnaires were returned. Of these, eight cases were eliminated due to "organic brain dysfunction", leaving 71 cases, 56 males and 15 females. The sample of 71 was composed of children with the following diagnoses at the time of institutionalization: passive aggressive personality, 41 (57%); psychoneurosis, 7 (9%); schizoid personality, 12 (17%); and childhood schizophrenia 11 (15%).[1]

The follow-up questionnaire focused primarily upon assessing patient outcome through responses to questions about further psychiatric treatment, institutionalization, school adjustment, problems with authorities, work history, overall emotional adjustment, and current symptoms of psychopathology.[2]

A schedule was applied to each former patient's case record noting the following information: psychiatric diagnosis, and IQ upon admission and discharge, length of

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[1]A. Davids and P. Salvatore, "Residential Treatment of Disturbed Children and Adequacy of Their Subsequent Adjustment: A Follow-Up Study," American Journal of Orthopsychiatry, XLVI (January, 1976), 65.

[2]Ibid., p. 66.

institutionalization, duration of psychotherapy, sex gender and professional disipline of therapists, duration and kinds of drug therapy, EEG data, parental involvement in casework and prognosis at time of discharge. Using the parents' rating of their offspring's overall emotional adjustment at time of follow-up, the former patients were classified into the following three groups: "good" 29 (41%); "fair" 22 (31%); and "poor" (28%).[1]

Insofar as preadmission variables were concerned, Davids and Salvatore noted several items were significantly different between the "good" group and the "poor" group. One such variable was "argumentativeness". This variable does differ significantly between the three follow-up groups with very few of the most successful cases having argumentativeness among their presenting symptoms. Another variable concerned "peculiar behavior/thinking-troublesome behavior of lying and stealing". Often children manifesting history of these behaviors at preadmission were more often judged to be making a "poor" adjustment in later years.[2]

No significant differences among the three groups in age at admission or age at discharge were established. The groups did not differ significantly on the duration of stay in the residential treatment center. However, it is noteworthy that a greater percentage of the cases in the

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[1]Ibid., p. 67.

[2]Ibid.

"good" adjustment category had parents who participated in psychiatric casework while the child was in residence, but this participation did not cause differences in the follow-up stage of the investigation.[1] Further, it is interesting to note in the follow-up "poor" category, more sets of parents participated in casework than for the "fairs" and "goods".

Other significant differences were found between the groups on the following variables: the percentage of cases showing "acting out" behavior was twice as large in the poor adjustment category; and "disobedience" was different between the groups. Related troublesome behaviors were found much more frequently in the poor adjustment group. These behaviors consisted of : lack of concentration, overeating, running away, sexual problems, stealing, temper tantrums and being easily upset. Another clearly differentiating rating is in the follow-up category of "work difficulties". None of the records of the group rated "good" contained a single complaint of disobedience, school failure, truancy, running away or work difficulties.

Other indices of adjustment revealed a higher percentage of the poor adjustment group had undergone further psychiatric teatment following discharge. There were, however, no time frames indicated regarding the occurrences of rehospitalization. (Fifty-eight percent of the

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[1]Ibid.

poor adjustment group had further residential psychiatric care compared to 21% for the good adjustment group.) About 90% of the poor adjustment group had experienced difficulties with the police while only one member of the good adjustment group had encountered such problems.[1]

Finally, an attempt was made to relate the prognostic ratings assigned at the time of discharge (good, fair and poor) to the three categories of adjustment found at follow-up. For the last variable then, an attempt was made to examine the child's status at discharge and relate it to eventual outcome. The finding here was that professionals may be able to predict those child cases destined for continued maladjustment, but were less able to predict future good adjustment. The researchers recommended this area as worthy of further study.

Table 1, page 83, summarizes the major findings from this review as it relates to the variables examined in the current study. In summarizing this information, the variable age was specified and noted. Cameron (1950) stated the child entering the residential-hospital unit at age 14 or older has a higher probability for positive subsequent adjustment than the child under 14 years of age.[2] Masterson (1956) tended to agree, but suggested the age

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[1]Ibid., pp. 68-69.

[2]Cameron, p. 113.

would be 15 years or older.[1] Weiss and Glasser (1965) affirmed that onset before adolescence was generally negative.[2] Conversely, Warren (1965) suggested age at admission below 14 1/2 was better prognostically.[3] Allerhand (1966) agreed but suggested the age should be 13 or below.[4] Taylor (1973) concurred that younger children had a better outcome at follow-up.[5]

Three studies suggested that age was unrelated to outcome: Masterson (1958),[6] Hartman (1969)[7] and Davids and Salvatore (1976).[8] Thus, there is apparently little consensus on the variable age and subsequent outcome.

The Hartman investigation (1969) addressed the second variable--placement in foster parent care prior to residential/hospital care--and the third variable--pre-admission group care. Hartman found no relationship between these variables and ultimate adaptation.[9]

Living with parents before admission was studied by

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[1]Masterson, "Prognosis in Adolescent Disorders: Schizophrenia", p. 113.

[2]Weiss and Glaser, p. 384.

[3]Warren, p. 154.

[4]Allerhand, p. 140.

[5]Tayler and Alpert, p. 51.

[6]Masterson, "Prognosis in Adolescent Disorders,", p. 1100.

[7]Hartman et al., p. 71.

[8]Davids and Salvatore, p. 68.

[9]Hartman, et al., p. 71.

Johnson and Reid (1947)[1] and Hartman et al. (1969).[2] Johnson and Reid noted most of the children who were in the residential treatment center happened to be from "non-intact homes". However, this information was not directly related to the current study since the current study was concerned with the child's relationship with either or both parents. Hartman concluded that living with parents before admission is unrelated to outcome.[3]

Frequency of parental involvement was examined as a variable by a number of authors. Johnson and Reid (1947) found a positive relationship between having parents involved and eventual outcome.[5] Hamilton observed (1961) that the "capacity of the parents", a trait he labeled "teachability", was an important variable in terms of outcome.[6] In 1969, Hartman et al. studied this variable and observed that in his opinion when both of the parents were being seen as a pair, a negative outcome often occurred.[7]

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[1]Johnson and Reid, p. 14.

[2]Hartman, et al., p. 71.

[3]Ibid.

[4]Ibid.

[5]Johnson and Reid, p. 19.

[6]Hamilton, p. 816.

[7]Hartman et al., p. 71.

In the seventies most investigators--Garber (1972),[1] Taylor (1973)[2] and Davids (1976)[3]--favored involvement of the parents concomitant with the child's therapy. Thus, overall, the material presented seemed to favor involvement of the parents and suggested it as important for the child's later adjustment.

Length of care and outcome was first mentioned in the literature by Annesley (1961) who suggested it was non-prognostic.[4] In 1965, Weiss and Glasser agreed.[5] Allerhand (1966) similarly concurred that it was non-prognostic.[6] In 1956, Morris, et al., noted that all children in the hospital manifested some "hospital improvement".[7] Hartman et al. (1969) suggested care over 18 months to be negative for eventual adaptation.[8] He interpreted this to be the case since most of the acutely

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[1]Garber, p. 70.

[2]Taylor and Alpert, p. 51.

[3]Davids and Salvatore, p. 64.

[4]Annesley, p. 271.

[5]Weiss and Glasser, p. 381.

[6]Allerhand and Weber, p. 145.

[7]Morris,et al. p. 993.

[8]Hartman, et al. p. 73.

disturbed tend to remain in care for longer periods of time. Garber (1972) suggested care less than six months related to a negative outcome.[1] Finally, Davids (1976) indicated length of care was not related to outcome.[2]

Disposition at discharge (where the child is headed) received minimal attention in the literature. Masterson (1956 and 1958) suggested any patient who was unimproved at the time of discharge was likely to have poor prognosis.[3] In 1962, Beskind noted about 65-75% of the clients in treatment showed "symptomatic improvement" at discharge, but no reference was made to patterns of adjustment for different dispositions upon discharge.[4] Weiss and Glasser found that discharge status was not predictive.[5] Hartman et al. (1969) did study the issue directly and found it non-prognostic.[6]

The first formal prediction schedules were found in the 1966 Allerhand and Weber study. The instruments used, however, were adjudged not helpful in terms of predicting

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[1]Garber, p. 80.

[2]Davids and Salvatore, p. 67.

[3]Masterson, "Prognosis in Adolescent Disorders: Schizophrenia," p. 230.

[4]Beskind, p. 365.

[5]Weiss and Glasser, p. 381.

[6]Hartman, et al., p. 73.

adjustment.[1] The King study (1969), used only informal psychiatric diagnoses as predictive tools.[2] The 1972 Garber study utilized a formal schedule for assessing community adjustment, but this schedule was not designed to predict adjustment from the point of client discharge.[3] Taylor and Alpert (1973) used a community adaptation schedule--the Roen-Burns scale--and proceeded to test hypotheses based on the case. This type of scale appeared to be particularly helpful inasmuch as it did assess the levels of community adjustment at the time of follow-up.[4]

In terms of rehospitalization or incarceration patterns, no study examined recidivism rates in terms of occurrence time after discharge. Masterson noted in 1965 that those with "poor outcome" had a greater chance of re-hospitalization,[5] and in 1958, he noted that "psychoneurotics" as a group within his study had fewer hospitalizations.[6] Hamilton and others (1961) noted contact after discharge was important for the subject in terms of maintaining support for the client.[7]

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[1]Allerhand and Weber, p. 140.

[2]King and Pittman, p. 1440.

[3]Garber, pp. 176-185.

[4]Taylor and Alpert, p. 50.

[5]Masterson, p. 230.

[6]Ibid., p. 1097.

[7]Hamilton, and others, p. 815.

Weiss and Glasser (1965) observed extensive "transitional" services may have a tendency to reduce the need for further inpatient service in the future for the client group.[1] Warren (1965) provided limited information on recurrence of problems after discharge through examination of hospitalization patterns with different groups of clients.[2] Beavers and Blumberg in 1968 provided similar information on client groups.[3] Garber (1972) also commented upon percentages of rehospitalization for various diagnostic groups.[4]

It was apparent from a review of the literature that information was lacking in many areas relating to this topic. What information was available at times appeared to be contradictory and ambiguous. Certainly many variables could have been chosen for the present study from a wide array of possible topics. Those selected are important since they are related to some of the conceptual issues being debated at this time. The review here has examined the child welfare model of residential treatment as well as the psychiatric hospital model. Examination of both these models of service provided a broad base upon which to proceed with analysis of a specific follow-up group.

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[1]Weiss and Glasser, p. 384.

[2]Warren, pp. 147-148.

[3]Beavers and Blumberg, p. 608.

[4]Garber, p. 102-103.

Table 1

Summary of Literature Review Findings

Positive Prognosis and Admission Age	Cameron 1950 14 and older	Masterson 1956 15 and older	Weiss and Glasser 1965 after adolescence
	Warren 1965 14.5 and younger	Allerhand and Weber, 1966 13 and younger	Hartman et al., 1969 no relationship
	Taylor and Alpert, 1973 younger children	Davids and Salvatore 1976, no relationship	
Positive Prognosis and Pre-admission Foster and/or Group Care	Hartman et al. 1969 no relationship		
Family Status Before Admission	Johnson and Reid, 1947 85% from non-intact homes	Hartman et al. 1969 no relationship to outcome	Taylor 1973 some relation-to outcome
Prognosis and Frequency of Parental Involvement	Johnson and Reid, 1947 no relationship	Hamilton et al. 1961, parents should be educated	Hartman et al., 1969 parents meeting social worker as a team, regularly
	Garber 1972 involvement is positive	Taylor 1973 involvement is positive	Davids and Salvatore 1976 involvement is positive

Table 1 (Continued)

Summary of Literature Review Findings

Length of Care	Morris et al. 1956 all improve with care	Annesley 1961 non-prognostic	Weiss and Glasser, 1965 non-prognostic
	Allerhand and Weber, 1966 non-prognostic	Hartman, et al. 1969 over 18 months, negative	Garber 1972 less than 6 months, negative
	Davids and Salvatore, 1976 no relationship		
Disposition at Discharge	Masterson 1956 no improvement at time of discharge is negative	Morris et al. 1956 most improved for about a year	Masterson 1958 no improvement at time of discharge is negative
	Beskind 1962 65-75% show symptomatic improvement at discharge	Weiss and Glasser, 1965 discharge status non-predictive	Hartman et al. 1969 no relationship to outcome
Prediction Instrument Used at Discharge	Masterson 1956 none used	Allerhand and Weber, 1966 formal schedule	King and Pittman 1969 psychiatric interview
	Garber 1972 formal predictive scales	Taylor and Alpert, 1973 Rosen-Burns Scale	

Table 1 (Continued)

Summary of Literature Review Findings

Re-hospitalization/ Other Confinement Information	Masterson 1956 poor growth increases probability of re-hospitalization	Masterson 1958 psychoneurotics are usually not re-hospitalized	Hamilton et al. 1961 contact after discharge is positive
	Weiss and Glasser, 1965 transitional services are positive	Warren 1965 limited information	Beavers and Blumberg 1968 information on hospitalization for various groups
	Garber 1972 information on hospitalization for various groups		

Chapter 3

RESEARCH DESIGN AND METHODOLOGY

GENERAL DESIGN

This study required information focusing on four stages in a client's adaptation process: 1) before the client's admission to Orchard Place, 2) during his/her stay at Orchard Place, 3) at the point of discharge and, 4) at the time of follow-up. To collect relevant data Orchard Place files on each subject were used to identify preadmission information as well as data from the time of residency at Orchard Place. For evaluation at the point of discharge, an instrument entitled the Health and Sickness Scale (HSS) was used.[1] To determine data at the time of follow-up an existing structured interview instrument[2] was modified for this study. This instrument was used for interviewing subjects and parent(s), relatives, or Department of Social Services personnel. Professional

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[1] W.T. Miller, "The Adolescent in Residential Treatment: A Twenty-Year Follow-Up Study" (unpublished manuscript, Topeka State Hospital, 1971), pp. 40-43.

[2] A. Davids and P. Salvatore, "Residential Treatment of Disturbed Children and Adequacy of their Subsequent Adjustment: A Follow-Up Study," American Journal of Orthopsychiatry, XLVI (January, 1976), 62.

staff were asked to review the HSS and the structured interview form and make comments on their use for the study. Both instruments were pilot tested (see Appendix) before use in this study.

Permission forms to take part in the study were signed by the child's parent/guardian disclosing that follow-up information could be requested as a means of helping Orchard Place evaluate its program. All participation in this follow-up study was totally voluntary and participants were kept anonymous.

The sample was comprised of 138 children out of a total of 199 identified as Orchard Place residents since program inception, February, 1965. Of the 138 children in the sample, three who had positively adapted had been in the group home program. Another 13 children had been in the evaluation unit only. Of the 13 from the evaluation program, nine were positive, four negative. All of the other subjects had been placed in the residential program. For purposes of data analysis, no differentiation was made along program lines. Subjects discharged after April, 1976, were excluded from this study. The data from casefiles were evaluated by judges from April, 1976, to June, 1976. The telephone interviews with subjects, parents, relatives, or Department of Social Services personnel began July, 1976, and concluded August, 1976.

Two judges, a male and a female, both trained in psychotherapy and residential treatment, were used to

screen files and locate data for the study. The judges evaluated subjects at the time of discharge and contacted the subjects for the structured interviews. They were trained in using the structured interview form and in using the HSS for discharge evaluation.

One of the judges was asked to collect on a 5 x 8 card the data relating to each of the seven variables in the hypotheses. Thus, each casefile was read and the following information recorded on a separate 5 x 8 card for each file: age at admission, the number of foster homes in which the child had been placed prior to admission, the number of group care facilities the child had been placed in including psychiatric hospital units, whether or not the child was living with parent(s) prior to residential care, the frequency of parental or surrogate involvement with the child during residence at Orchard Place, the length of actual residential care, and the destination of the child at point of discharge.

Both judges were then asked to read the entire casefile and assign a value of 0-100 on the HSS based on the subject's status at the point of discharge from Orchard Place. After the judges completed rating with the HSS, they were asked to confer and compare their ratings for each subject. If the judges assigned ratings to the subject not more than 15 points different on the HSS, a mean was computed and used as the rating assigned the subject. If the difference exceeded 15 points, the

judges conferred and arrived at a consensus through review of the file and further discussion. The 15 point criterion was used to coincide with major differences on the outcome intervals of the HSS. A difference of more than 15 points would put a subject at two different sickness categories on the HSS; consequently the averaging of these scores would be likely to produce an unrealistic picture of the subject's actual condition.

Following these procedures, the judges then proceeded to contact the subjects, relatives, parents, or Department of Social Services personnel to obtain data for completion of the structured interview. Telephone interview contacts were used. The data generated by the structured interview and the 5 x 8 cards were tabulated and analyzed to answer the questions and to test the hypotheses posed for the study.

POPULATION AND SAMPLE

The population represented by the study included pre-adolescent and adolescent children from families whose socio-economic backgrounds ranged from upper-middle class to lower-lower class and who resided in suburban, rural, and metropolitan areas in the midwestern United States.

The sample was selected from a residential treatment center located in Des Moines, Iowa, and no random sampling procedure was used to select the sample studied. Due to the inherent difficulties in locating subjects following

discharge, an attempt was made to contact all subjects who had been involved in Orchard Place residential programs.

Most of the children (over 99%) placed at Orchard Place have been from the state of Iowa. Generally, many of the children in placement are from Polk county, Iowa, and at any given time account for between 40% to 60% of the total population in residence.

Almost the entire sample had received services from various agencies prior to placement at Orchard Place. That is, some type of interventive effort had been attempted prior to placement.

DATA AND INSTRUMENTATION

The data from this study were drawn from the responses contained in the structured interview form and from casefiles on the subject during residence. To obtain data about the subject's placement in foster homes or group homes, age at admission, person with whom the child was living prior to Orchard Place placement, length of residential care, parental involvement and disposition at discharge, the casefiles for each subject were analyzed. The casefiles provided reports and data from professionals ranging from psychiatrists to educators whose information, specifically around adjustment in Orchard Place at the point of discharge, enabled the judges to rate the child on the HSS.

For purposes of this study, a definition of adap-

tation at follow-up was developed. Positive (+) adaptation included those subjects who had neither been hospitalized in a psychiatric hospital setting nor had been placed in a correctional setting since time of Orchard Place discharge, except a voluntary placement. Voluntary placement meant that the subject would consent to a short-term psychiatric stay no longer than thirty days. Voluntary placement in a correctional setting occurred in a few instances for family disturbances, not subject delinquency. Thirty days of hospital care was selected as an arbitrary guideline for the study since the subject's consent to hospitalization represents an understanding on the part of the subject that help is required. Any involuntary psychiatric admission or incarceration for criminal activity was defined as a negative (-) adaptation. Where a subject experienced several psychiatric confinements on a voluntary basis over time, but no more than one in a twelve month period, a thirty days total was used to evaluate adaptation. A subject who had two voluntary hospitalizations in one year was rated as a negative (-) adaptation.

These data pertaining to hospitalizations and incarcerations, if any, were included on the structured interview form. The above definition of adaptation was then applied to each of the 138 cases located for the study. Each subject was rated as a (+) or (-) adaptation and this information was placed on the 5 x 8 note card.

The instrument used for evaluating the status and

functioning of the subjects at discharge was the Health Sickness Scale (HSS). The instrument, developed at the Menninger Foundation, was designed to measure how well clinicians judged the status of mental health functioning for adults. It was used in at least eighteen research projects and continues to be used at the Menninger Foundation.[1] Miller modified the scale for a follow-up study at the Topeka State Hospital adolescent unit.[2] The modified HSS was used in this study.

The modified HSS, like the original scale, has a 100 point scale. The scale ranges from 0--a condition which if unattended would quickly result in the death of the patient, but not necessarily at his own hand--to 100--an ideal state of complete functioning integration, of resiliency during stress, of happiness and social effectiveness.[3]

Miller modified the original HSS through the following procedures:

> Forty examples of symptoms such as withdrawal, suicidal attempt, hallucinations, somatic delusions, were drawn from the total sample of 66 subjects. These were coded one through forty and were independently ranked by two judges according to the

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[1] L. Luborsky, "Clinicians' Judgements of Mental Health: Speciman Case Descriptions and Forms for the Health-Sickness Rating Scale," Bulletin of the Menninger Clinic, XXXIX (1975), 448.

[2] Miller, pp. 40-43.

[3] Luborsky, p. 448.

directions given by Luborsky. Sixteen of the examples which had judges' agreement were selected as meaningful examples of certain points. These were then used as additional examples of the general scale point definitions already given by Luborsky.[1]

Miller redefined selected points on the HSS that appeared relevant for a child population. The modified HSS has descriptions of the subject's functioning, and the judges proceeded to review the description coinciding with different points along the scale and then rated the subject accordingly. The HSS modified is certainly to be regarded as an experimental scale subject to further validation. It was selected for purposes of this study since it had been used in a setting that was similar to Orchard Place, and it enabled the judges to determine a rating based upon an outcome of treatment.

After each of the files had been rated by the judges, all information was placed on the 5 x 8 card. These data were then keypunched. Contingency tables were then developed to test the hypotheses and answer the questions raised by the study.

ANALYSIS

The questions raised and bearing upon this study included the following:

1. What were the child's preadmission life experiences in terms of actual living experiences?

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[1]Letter from Dr. W.T. Miller, psychologist, June 21, 1976.

2. What were the essential variables influencing long-term adaptation of the subject?

3. What information could be discerned to predict the subject's eventual adaptation?

4. What information could be gathered to identify the effects of residential treatment on subjects?

In addition to testing the null hypotheses the HSS was correlated with adaptation of subjects and a table was developed showing the onset of negative adaptation for those subjects. To obtain as comprehensive a profile as possible of how the subjects were faring, some secondary topics were included on the structured interview form. These data are presented in Chapter 4.

The null hypotheses were tested with Chi-square, which was the most appropriate statistic due to its usefulness with discrete data in the form of frequencies. An alpha of .05 was considered adequate to reject the null hypothesis in each case.

Chapter 4

FINDINGS

Table 2 offers a general description of the final sample obtained for this study. The sample consisted of 69.34% of all contacted, representing 138 cases from 1965 until April, 1976. Of the 138 cases identified, 96 were evaluated as positive adaptation and 42 as negative adaptation. Another 61 cases were not located. Table 3 shows a description of those cases not contacted for the study.

Table 2

Description of the Sample Obtained From the Total Population

Positive Adaptation	Negative Adaptation	Inadequate/ No response	Total
96	42	61	199

For those cases not contacted the following categories were used. First, "insufficient information" means data from the structured questionnaire essential to the evaluation was absent. This ranged from missing data on the nature of a hospitalization to uncertainty of the overall status of the subject. Second, "no contact"

means that it was not possible to make contact with the subject either through telephone or through other means such as correspondence. Every practical means were explored before assignment to this category. Third, "withdrawn from treatment" refers to subjects removed from care before the study was completed. Fourth, "elopement" means that the subject left the program and was not available for contact. Thus, it was not possible to assess the status of the subject as discharge. Fifth, "death" claimed two subjects. Sixth, "refusal to participate in study" means that several respondents chose not to participate. Seventh, "other" refers to responses coming after the expressed deadline and, therefore, not included in the final data processing procedures.

Table 3

Description of the Disposition of Cases Not Contacted for the Study

Disposition	Number	Percent
No contact with data source	38	63
Insufficient data from questionnaire	8	13
Withdrawn from treatment against agency recommendation	5	8
Refusal to participate in the study	3	5
Other	3	5
Elopement from program	2	3
Death	2	3
Total	61	100%

Table 4 describes respondents surveyed to complete the structured interview form. Table 5 shows the statistical testing of the null hypothesis involving the variable age with adaptation. The age ranges included 6-9 years, 10-13 years, and 14-17 years. Historically, no child has been admitted before age 6, while 16 years is the upper age limit for admission. The Chi-square test resulted in a non-significant statistical relationship between age at admission and adaptation (p=.28). The finding from the statistical test indicates that age with adaptation is independent and the null hypothesis was accepted.

Table 4

Respondents Surveyed to Complete the Structured Interview Form

Respondents	Number	Percent
Parents	62	45
Subjects	45	33
Other professionals	15	11
Department of Social Services	10	7
Relatives	6	4
Total	138	100%

The second null hypothesis tested was the number of foster placements experienced with each subject prior to the placement at Orchard Place. A rationale for testing this hypothesis was to determine if multiple placements whereby

a subject was placed in several foster parent homes prior to admission into a residential center was associated with either positive or negative adaptation patterns. It is important to note that this hypothesis was designed to measure only foster home placements, not other types of foster care living arrangements for the subjects.

Table 5

Relationship of Adaptation Status with Age of Child at Admission

Age	Positive Adaptation	Negative Adaptation
6-9	23	6
10-13	29	14
14-17	44	22
Total	96	42

$X^2=3.785$, $p=.28$

Table 6 shows the numbers of foster home placements with adaptation. It is noted that 72% of the positive (+) group did not experience any foster home placements; in the case of the negative (-) group, 68% had no foster home placements.

The findings relative to Table 6 indicate that the null hypothesis is accepted as the variable number of

foster home placements with adaptation are apparently independent of each other (p=.30).

Table 6

Relationship of Adaptation Status with the Number of Foster Placements for Each Subject

Number of Foster Care Placements	Positive Adaptation (+)	Negative Adaptation (-)
1-2	22	9
3 or more	5	5
Total	27	14

X^2=1.475, p=.30

The third null hypothesis tested the relationship of group care with adaptation. The variable group care, for purposes of this study, meant placement in any of the following types of settings: private or public psychiatric hospital setting; group home; residential treatment center; detention center; or any other type of group caring facility. In interpreting these data, it is important to note that any group care placement was charted, and the frequency of each placement for each subject was charted. Put another way, if the subject had been placed in a group caring facility prior to Orchard Place admission, this was charted as one group care placement. If any group care placement occurred in the subject's history, it was recorded.

Table 7 deals with group care prior to Orchard Place

admission. Group care placement with adaptation was statistically highly significant (X^2=17.364, $p < .001$). This means that the null hypothesis was rejected and that a dependent relationship exists between group care placement for subjects prior to admission and adaptation.

Table 7

Adaptation with Group Care Placements and Non-Group Care Placements Occurring Before Orchard Place Admission

Number of Group Care Placements	Positive Adaptation	Negative Adaptation
0	68	18
1	14	16
2 or more	14	8
Total	96	42

X^2=17.374, $p < .001$

The next null hypothesis tested was the relationship between living with parent(s) prior to Orchard Place admission and adaptation. If the subject was not living with parent(s) at the time of admission, the subject was viewed as "not living with parents". It is noted that if the subject was not living with parent(s), the subject would likely have been placed in some type of alternate care.

A statistically significant relationship (X^2=17.364,

$p < .001$) was obtained, thus rejecting the null hypothesis. Consequently, a dependent relationship appears to exist between living with parent(s) and adaptation (see Table 8).

Table 8

Subject Residence with Adaptation Prior to Orchard Place Admission

Condition	Positive Adaptation	Negative Adaptation
With Parent(s)	73	18
Not with Parent(s)	23	24
Total	96	42

$X^2 = 18.533$, $p < .001$

The next null hypothesis tested was that of frequency of parental involvement with adaptation. As a matter of admission policy, Orchard Place has always required parental involvement. Typically, there have been great variations around the actual frequency of parental contact. Such variations have been a product of distance to the parental home, the nature of parental problems and the degree of commitment the parents are able to manifest toward their child's residential treatment program.

The frequency of parental contact was operationalized around the most frequent patterns which professional colleagues had identified over time. The frequencies involved weekly involvement, every other week involvement,

monthly involvement, random involvement (identified as the parent(s) coming to the agency in frequencies over one month apart), and non-involvement. Despite efforts to obtain a commitment that the parents would support treatment, a number of parents would make a verbal commitment but not follow through for numerous reasons. Eventually such children would be eligible for program discharge, since it was felt inadvisable to retain a child in the residential program without the active and intense participation of the parents in the treatment aspect. This hypothesis sought to test whether actual parental involvement had a direct impact upon long-range adaptation. Table 9 deals with this hypothesis.

The null hypothesis was accepted (X^2=8.302, p=.14). This was interpreted to signify that the variables, frequency of parental contact and adaptation, were independent of each other.

The next null hypothesis studied was the relationship between length of residential care and adaptation patterns. The time span of residential care was arranged along a continuum from zero months to four or more years. Such points represented the extremes of the residential time frames. It was felt that this was an important area to test to determine if adaptation was a function of length of

stay for the subjects.

Table 9

Frequency of Parental Involvement with the Child in Residential Treatment and Adaptation Patterns

Condition	Positive Adaptation	Negative Adaptation
Weekly visits	5	5
Every other week visits	35	5
Monthly visits	27	11
Random	18	9
Non-involvement	11	12
Total	96	42

$X^2=8.302$, p=.14

This hypothesis was accepted ($X^2=7.271$, p=29). Apparently length of residential stay is independent of adaptation (see Table 10).

The next hypothesis studied was disposition at discharge with adaptation. For purposes of this report, disposition at discharge was defined as where the subject was heading upon discharge. At the time of a subject's discharge, a number of alternatives are feasible. These range from return to the parent's home, foster parent care, group homes, or placement in another residential or psychiatric hospital setting. Such living alternatives were

identified after analysis of the actual discharge patterns became known.

Table 10

Length of Residential Treatment Program Adaptation Patterns

Condition	Positive Adaptation	Negative Adaptation
0-12 months	30	10
13-24 months	26	11
25-37 months	22	12
37-48 or more months	18	9
Total	96	42

$X^2=7.272$, $p=.29$

Each living arrangement offers different possibilities for a given subject. A long standing objective of the Orchard Place program has been to return the child to the natural parent(s) whenever or wherever possible. At the same time, however, no data were available which compared adaptation patterns with placement plans for the child immediately following the residential treatment experience.

Table 11 shows the data used to test the null hypothesis dealing with disposition at discharge with adaptation. The null hypothesis was rejected ($X^2=50.578$, $p<.001$). This finding suggests that the variables, disposition at discharge with adaptation, are apparently

dependent upon each other.

Table 11

Disposition at Discharge
Adaptation Patterns

Disposition	Positive Adaptation	Negative Adaptation
Home	65	11
Foster Parent Care	19	5
Group Care	12	9
Hospital	0	17
Total	96	42

$X^2=50.578$, $p < .001$

A related finding concerns the observation that none of the positively adapted subjects was discharged from Orchard Place into a psychiatric hospital setting. In the case of the negatively adapted subjects, 17 had to be removed from the residential unit into a more closed psychiatric hospital type of setting. Generally, such removal from treatment and placement in a psychiatric setting occurred around crisis type behavior when the subject was a threat to self, other children, or staff.

Another purpose of the study was to analyze the effect of the residential treatment experience. This was done in two ways. First, an analysis was made of the

negative adaptation cases to determine the onset of the hospitalizatiin or incarceration. It was believed that collection of such data would be meaningful in terms of giving a picture of how long one might expect the positive effects of residential treatment to persist. Second, to predict at discharge those subjects who had the greatest probability of success in terms of successful adjustment to community life. If high positive scores on the HSS tended to be associated with positive adaptation at follow-up, such an association would support the possibility that the gains made during the residential experience tended to maintain themselves with the subjects at follow-up. Table 12 shows the onset of hospitalization or incarceration of subjects with respect to time of discharge from Orchard Place.

Of those who were identified as negative adaptation at follow-up, it is noteworthy that 45% of such adaptations occurred within the first three months following discharge. An additional 10% were rated as negative adaptations through the first six months, and another 14% within the first year. Thus, fully 69% of all subjects who were rated as negative adaptations were so rated within the first year of discharge from Orchard Place. Almost one-half of all negative adaptations occurred within the first three months. No negative cases were identified after the seventh year.

Table 12

Onset of Hospitalization or Incarceration of Subject with Respect to Time of Discharge from Orchard Place

Time	Number	Percent
0-2.9 months	18	45.2
3.0-5.9 months	4	9.5
6-11.9 months	6	14.3
12-23.9 months	6	14.3
24-35.9 months	1	2.4
36-47.9 months	0	0.0
48-59.9 months	0	0.0
60-71.9 months	1	2.4
72-84 months	5	11.9
Total	42	100.0%

The HSS was used to evaluate the subject's status at the actual point of Orchard Place discharge. The HSS is arranged in such a way that the high scores are identified with higher levels of functioning than are lower scores. A score of 80 is higher and indicative of a higher level of psychological functioning than a score of 30. Thus, if subjects who received high HSS scores were rated as positive adaptation at follow-up, it was determined that the HSS could be used as a predictive device to identify those subjects likely to work out a successful adjustment in

the community. If high HSS scores were associated with subjects who were rated at follow-up as negative adaptations, then it was apparent that the HSS could not be utilized to differentiate between the negative and positive groups.

Table 13 describes the relationship between HSS scores with adaptation at follow-up (X^2=36.884, $p<.001$). The highest value on the HSS was 78 with 100 possible. The lowest value identified was 15. The mode for positive (+) was in the class 56-65. For negative adaptations, the mode was the 36-45 class. The mean of all scores was 70.61.

Table 13

The Health Sickness Scale (HSS)
And Adaptation

HSS Scores	Positive Adaptation	Negative Adaptation
76-85	1	0
66-75	16	2
56-65	41	4
46-55	17	6
36-45	11	12
26-35	5	5
15-25	5	13
Total	96	42

X^2=36.884, $p<.001$

A number of additional tables were developed from the

structured questionnaire which served to provide further data on an overall view of the subjects' functioning within the community. Such tables provided information that served to outline a profile of subjects' activity in the community to determine not only how the subjects fared, but to what degree they had utilized community resources. Chi-square comparisons have been included where possible to describe the statistical relationship between the variables involved. In other tables only frequency data were included.

Table 14 deals with the equality of school adjustment for the subjects enrolled in school at the time of follow up with adaptation. Of the group in school, those described as having "very good" adaptation to school were 33% of the (+) group. This compares to 0% for the (-) group. In terms of the next classification, "good" adjustment, 18 or 36% were in this class compared to the (-) group where 6 or 42% were found. In the last class, "fair", 15 of 31% were so rated in the (+) group while 8 or 57% were so rated for the (-) group. In the classifications "very good" and "good", the number of (+) subjects was almost five times that of the (-) group of subjects. In the classification "fair" the (-) group exceeded the (+) group by three cases. It was apparent that the (+) group tended to enjoy a higher subjective experience of school success compared to the (-) group of subjects.

Table 14

Quality of School Adjustment for Those Subjects Enrolled in School with Adaptation

Condition	Positive Adaptation	Negative Adaptation
Very Good	16	0
Good	18	6
Fair	5	8
Total	39	14

Table 15 shows the current grade placement for subjects enrolled with adaptation. A total of 58 subjects was identified as still in school. In terms of total numbers, 58 or 60% of the (+) group were still involved in some type of educational program at follow-up compared to 17 or 40% for the (-) group of subjects. In terms of groupings, the (+) group had 16% of the total group enrolled in elementary school compared to 6% for the (-) group. (Elementary defined as grades from 1 through 6.) Junior high school (grades 7 through 9) showed 32% for the (+) group while for the (-) group, 35% were in junior high school at the time of follow-up. Senior high school (grades 10 through 12) showed 25% for the (+) group and 6% for the (-) group. Further, it was observed that the (+) group had 10% of its subjects in college, while none of the negative subjects were apparently in college. Further training,

beyond four years of college education was shown with 2% of the (+) group and none of the (-) subjects.

It is noteworthy that special education showed 9% enrollment for the (+) group; 47% for the (-) group. Over five times as many of the (-) subjects apparently required a special education program. The large number of enrollees supported the observation that a group of negatively adapted subjects have profound needs in different areas of psychosocial and psychoeducational functioning.

Table 15

Current Grade Placement with Adaptation for Those Subjects in School at the Time of Follow-Up

Grade Level	Positive Adaptation	Percent	Negative Adaptation	Percent
3	1	2	0	0
4	1	2	0	0
5	2	3	0	0
6	5	9	1	6
7	4	7	0	0
8	8	14	2	12
9	7	12	4	23
10	3	5	1	6
11	10	17	0	0
12	2	3	0	0
Special Ed.	5	9	8	47
College	6	10	0	0
College 4+ years	1	2	0	0
Unknown	3	5	1	6
Total	58	100%	17	100%

Table 16 shows the highest grade attained for those subjects no longer in school at follow-up. This table indicated that of the (+) group, none of the subjects had terminated their education at elementary school level. Insofar as the (-) group, 12% had terminated at the conclusion of the elementary school program. For junior high school, grades 7 to 9 inclusive, the positive group showed 16% had terminated. For the (-) group, 20% had terminated during junior high school years. Between 10 and 12th grades, 24% of the (+) group had terminated, while 16% of the (-) group had terminated. With the (+) group, 36% had completed high school education while the (-) group showed 12% completing high school graduation. In terms of advanced training, Table 16 shows that the (+) group had 5% college graduates and no college graduates for the (-) group. Of those terminating at graduate or professional school level, 3% were of the (+) group and none from the (-) group.

An important area of data, relating to the follow-up of subjects, concerned their relationship with the community. It was hypothesized that several important aspects of the subjects' relationship to the community might be determined through assessment of selected areas of community participation or involvement. It was speculated that subjects would tend to fare better with increased involvement in community activities. The areas chosen to measure such involvement included church attendance and the

number of friendships identified by subjects. Tables 17 and 18 present these data.

Table 16

Highest Grade Attained with Adaptation for Subjects no Longer in School at Follow-Up

Grade Level	Positive Adaptation	Percent	Negative Adaptation	Percent
4	0	0	0	0
5	0	0	1	4
6	0	0	2	8
7	0	0	1	4
8	3	8	2	8
9	3	8	2	8
10	5	13	2	8
11	4	11	2	8
12	0	0	0	0
High School Graduate	14	36	3	12
GED	1	3	1	4
College Graduate	2	5	0	0
Graduate/Professional School	1	3	0	0
Unknown	5	13	9	36
Total	38	100%	25	100%

Table 17 shows the relationship of church attendance to adaptation. This table seeks only to determine whether the subjects were, in fact, participating in any type of church activities. It did not attempt to assess any other data. A statistically significant relationship was found to

exist between church attendance and adaptation.

Table 17

Relationship of Church Attendance to Adaptation

Attendance	Positive Adaptation	Negative Adaptation
Yes	51	14
No	42	28
Total	93	42

$X^2=5.359$, $p<.05$

Number of friendships perceived by subjects with adaptation is shown in Table 18. No attempt was made to determine the nature of such friendships, only the number of friendships perceived in relationship to a specific subject. A statistically significant relationship ($X^2=7.893$, $p<.01$) existed between the number of friendships and adaptation.

Table 19 deals with the relationship of overall adjustment to adaptation. About 85% of the (+) subjects were classified as "better"; 45% of the (-) group were also "better". In terms of the rating, "same", about 11% were (+), while 29% were (-). For the "worse" group, 4% were (+), and were rated as "worse" from the (-) group (see Table 19).

Table 18

Number of Subjects' Friends Perceived in Relationship to Adaptation

Number of Friends	Positive Adaptation	Negative Adaptation
Many (5+)	41	10
Some 2-4	30	9
Few or None 0-1	22	18
Total	93	27

$X^2=7.892$, $p<.01$

Table 19

Relationship of Subjects' Current Adjustment to Adaptation

Evaluation	Positive Adaptation	Percent	Negative Adaptation	Percent
Better	80	85	19	45
Same	10	11	12	29
Worse	4	4	11	26
Total	94	100%	42	100%

$X^2=44.063$, $p<.001$

Table 20 shows the relationship between subjects' participation in out-patient psychiatric services and adaptation patterns. It was hypothesized that there would be a difference between the (-) and (+) groups on the basis of continuation in some type of supportive therapeutic activities. Such therapeutic support could serve to preclude hospitalizations or incarcerations. The data revealed no significant relationship.

Table 20

Subjects' Participation in Out-patient Psychiatric Care Since Orchard Place Discharge with Adaptation

Participation	Positive Adaptation	Negative Adaptation
Yes	41	11
No	52	27
Total	93	38

$X^2=1.784$, $p<.20$

The structured questionnaire collected data on many other topics such as employment, marital status, and related areas. Such data were not included in the report inasmuch as it was believed some of the questions presumed certain eligibility such as age and physical or mental conditions which were beyond the boundaries of this investigation.

SUMMARY OF FINDINGS

This was a follow-up investigation of subjects discharged from Orchard Place between February, 1965, through April, 1976. Over this 11 year period, 199 subjects had been in the residential treatment center. Of these, 138 subjects were located and contacted to complete the structured interview form. Each subjects' casefile was evaluated to assemble data on the hypotheses. Evaluation of subjects' status at discharge was used to complete the HSS.

The number of group care placements experienced by the subject prior to Orchard Place admission, disposition at discharge, and whether the subject was living with parent(s) before Orchard Place admission were found to be related to adaptation. The other hypotheses tested, age at admission, length of residential care, frequency of parental involvement, and number of preadmission foster care placements were found to be unrelated to adaptation.

It was found that the HSS differentiated between the (+) and the (-) groups at follow-up. That is, higher scores on the HSS were associated with positive adaptation of the subjects; lower scores on the HSS were associated with negative adaptation. Such prediction was based, then, upon the psychosocial status of the subject at point of discharge from Orchard Place.

Highest educational attainment for subjects was reported as follows. For the (+) group, 36% had terminated

their educational activity with a high school education. This compared to 12% of the (-) group terminating with a high school education. Educational drop out was highest for the (-) group at the junior high school range, 7 to 9th grade. Here it was found that 20% of the (-) group had terminated. The highest drop out range for the (+) subjects appeared to be high school, 10th through 12th grades. Twenty-four percent terminated their education during high school years. In terms of advanced training, 5% of the (+) subjects had completed college and 3% had terminated at the graduate school level.

Subjects' relationship to the community was assessed through church attendance and number of friendships. The findings indicated that church attendance and number of friends were related to adaptation. Both of these factors, church attendance and number of friends, appear important in assisting the subjects to remain attached and related to the community.

This study also included an attempt to assess the subjects' current adjustment. This assessment revealed about 2 (+) subjects to 1 (-) subject tended to be in the classification "very good" adjustment. This ratio was true for the classification "same" for both groups. For the "worse" group, about one(+) subject for every six (-) subjects was identified for the lowest functioning scale on the table. Generally, it was found that the (+) subjects were functioning on higher levels of adjustment than were

the (-) group of subjects. Fewer (+) subjects were found in the "worse" group.

Chapter 5

DISCUSSION, CONCLUSIONS, RECOMMENDATIONS

DISCUSSION

First, of the null hypotheses presented and studied, it was found that three of the seven showed statistically significant correlation with adaptation patterns. These were: group care placement, living with parent(s) prior to admission, and disposition of the child at discharge as related to adaptation. A significant relationship was also established between the HSS with adaptation. The other null hypotheses were accepted. Those hypotheses which were statistically significant appeared to be critical in terms of predicting the eventual adaptation of the subject.

Historically, one of the shifts which has occurred is the development of the "least restrictive" principle in terms of foster care placement. This means that the child who requires out of home services must receive such services in the facility which is least restrictive. As it relates to understanding the statistically significant hypotheses, it is suggested that youths entering residential centers within the recent past are coming directly from secure group caring facilities; however, in the past, before the philosophical shift occurred, such youths may have come

directly from home settings. Youths entering the group caring facilities prior to admission in definitive residential treatment centers may well represent a population which has acted out behaviorally in other "least restrictive" settings and, in turn, were moved to a more structured type of group care settings. Such young people may well have been moved through the residential centers without receiving sufficient intervention. This lack of intervention could lead them to become involved with subsequent hospitalizations and possible criminal activity. Since these youths were unable to respond positively to earlier and less intense intervention, their presence may well signal the receiving residential center of profound psychosocial needs. Such placements should be viewed with special concern by the staff of the residential center.

Another hypothesis which was statistically significant with adaptation involved whether or not those entering Orchard Place were coming from a parental environment, or if they were entering the residential program from some other source. The reason for selecting this hypothesis initially was that it was believed youths entering residential treatment services from their home environment were more likely to have parental commitment, and, in turn, feel more supported by their respective families. Such support would enable them to utilize the treatment program maximally. Another possibility for rejection of this hypothesis is that the youths who have been placed outside of their homes

would not be entering residential treatment from there but rather from such sources as group caring facilities, state hospital settings, foster homes, or possibly, relatives' homes. That this is the case appears more likely since, in the last analysis, parental support must be granted at some level for the placement to occur at all. Without parental support, it is unlikely that the placement could be consummated in view of the increasing legal regulations pertaining to this area. Thus, it appears that the relationship of prior living with parent(s) and adaptation may be that youths not coming from their own homes but from other sources have not responded to other types of intervention and consequently represent a population whose behavior and controls are such that they are unable to remain at home and must be placed in settings which may appropriately protect them.

Disposition at discharge was another hypothesis which was significant with adaptation. Disposition was viewed as an important aspect of the termination phase of the child's residential treatment program. A long standing agency practice has been to return the child to the natural parents whenever feasible. An important factor in this hypothesis was the large number of youths returning to their homes from the residential center who were later evaluated as (+) subjects. A total of 65 subjects of the (+) group were returned home compared to 11 of the (-) subjects. It is apparent that the large numbers of children

returned home with the (+) group accounted for this significant relationship. This finding suggests clearly that returning the child to his/her home from the residential treatment center is of major importance in the long range adaptation of the subject.

This investigation revealed that the HSS was able to differentiate between positive and negative adaptation. Since higher HSS scores tended to be associated with positive adaptation, this study suggests that such an instrument may have practical use at the time of discharge in making predictions based upon a quantitative assessment of the dischargee. Another point relating to the HSS concerns maintenance of gains from the residential treatment experience. If the gains made during residential service are quantifiable at discharge and such gains tend to be associated with high HSS values and positive adaptation, it may be inferred that the gains made during treatment will be maintained over time. Such maintenance or absence of gains over time, if accurately predicted at discharge, would have considerable significance in identifying subjects who may continue to require specialized resources.

The other hypotheses tested for the study were accepted as null hypotheses. No significant statistical relationship could be identified between age at admission, frequency of parental involvement, length of residential care and number of preadmission foster care replacements.

As noted in the review of literature, disagreement

was found with respect to the age of admission and its significance to later adjustment. In this study, age was not found to be associated with adaptation, and the study did not shed further light on the topic of age and its significance for long-range adaptation.

The null hypothesis relating to the number of preadmission foster care placements was also accepted. The data suggested that the number of foster care placements did not differentiate between the (+) and (-) groups. Interpretation of this finding would suggest that foster parent care may offer another level of service, uniquely different from group care whereby children may not be manifesting as severe or as intense psychosocial needs as youths entering group care before admission.

The retention of the null hypothesis regarding family involvement was surprising. The literature is replete with references to the significance of family involvement with the child placed outside of the home. One possible interpretation, however, is that the report measured involvement discretely, not qualitatively. More visiting was not necessarily associated with better visits. The fact that some visiting did occur with the subject in residence may, however, be vital to long range adaptation of the subject. The actual frequency of family visitation or family counseling procedures may not be as important compared to the quality of the intervention both on the part of all involved--counselor, subject and family.

Length of residential care was not associated with adaptation patterns. Such a finding is interesting in view of the residential care costs and the current emphasis upon reuniting child and family in the shortest time feasible. It is noted that the length of residential care in Orchard Place is under constant review at a number of different clinical and administrative levels. Such reviews include interdisciplinary team meetings and psychiatric meetings regarding the subject in residence. A number of steps are built into the program to insure that the subject is in residence for only the amount of time required to complete the original goals of placement.

A partial answer for length of care not being associated with adaptation may be that a residential center such as Orchard Place is serving a different population of youths whose treatment goals can be attained and another population of youths who are highly resistive and non-responsive to treatment procedures. When viewed together, adaptation and length of stay would not be statistically significant; however, if the groups could be separated, it is postulated that length of stay might well be significant with adaptation. This remains only a possibility for further study. Thus, youths who are non-responsive and more resistant to treatment would tend to stay longer in the residential program increasing the length of stay. Yet, due to their profound psychosocial needs, adaptation patterns may remain negative. The agency may wish to develop

specific programs which would be targeted in for the special needs of such youth.

Additional data collected on the structured interview indicated that the group of (+) subjects tended to have better ratings on school adjustment, if enrolled; more (+) subjects than (-) subjects were enrolled in school at the time of follow-up; the (+) group had overall higher levels of educational attainment. In terms of community relationships, the (+) and (-) groups showed differences in terms of church participation and friendships, two factors of community involvement. Such differences were statistically significant between the (+) and (-) subjects. This finding possibly indicates that (+) subjects appear to have a deeper sense of attachment to the community and, in turn, may feel differently toward the larger community. Further, such attachment may enable them to control more resources to meet their needs and feel mastery over their own destinies. No relationship was found beween the subjects receiving further psychiatric outpatient services and subsequent adaptation.

The data gathered describing educational patterns, educational adjustment, and community relationships, tend to indicate that the group of (+) subjects apparently fare better after discharge. Such a statement is further supported by the assessment question asking how subjects were faring in their current life situaiton. Subjects of the (+) group tended to rate themselves or were rated by others as

functioning on higher levels of adjustment in the community after discharge.

Another purpose of the study was to measure the relative impact of the agency's program upon the target population. The findings of the study indicate that an approximate positive adaptation index of 69.34% was determined for all subjects identified as former residents of Orchard Place. It is difficult to compare this figure with other studies reviewed for this report because of different success criteria for subjects. A relative comparison with those studies that appeared generally similar showed Allerhand's study with a success rate of 74% and the Garber study with 79%. Such relative comparisons leave much to be desired as many assumptions underlie comparison efforts. An important aspect of this investigation is that evaluation of the subjects occurred using the entire discharge time as a frame of reference for evaluation. Of course, the risk of negative adaptation was spread over the entire period of time in contrast to evaluation of the subject based solely upon the status of the subject at a given moment in time.

Another purpose of the study was to determine when, if at all, negative adaptations occurred. The study was successful in identifying that a critical time-frame was up to three months after discharge. Nearly half of the negative adaptations occurred within three months of discharge. An analysis of this finding showed that once discharged, sub-

jects tended to move either toward or away from a successful adjustment to community life. Also, note that included within the first three months' data are those subjects who were involved in out of bounds behavior or crisis situations necessitating their placement in a more secure type of setting.

There are two observations related to this finding: first, although the agency offers continued outpatient services to the subject and family following discharge, more intense services may need to be offered within local community mental health centers for those subjects living considerable distance from Orchard Place. Second, those subjects whose behavior is excessively out of bounds for the agency to handle may be another sign of the population of youths who are in residential centers and yet whose psychosocial needs may require more secure facilities. Such youth may not always be identified at the time of admission into the program.

A final goal of this study was to provide basic information regarding the outcome of subjects to compare observations with working assumptions of treatment methodology. First, youths who are outside the home at time of admission and/or who have multiple group caring placements in their history should receive a careful review prior to admission. If such youths are admitted, it is possible that a special review system may be operationalized to track their progress and insure that the program

is meeting the needs of the client. Second, discharge plans should be clearly identified and formulated enabling, wherever possible, professionals in the youth's home community to provide support and continuity. Third, if the HSS is used at the agency in the future for evaluating discharges, those youths who are below 50 on the HSS should be viewed "risky", and care-takers of the youths should be advised of the need for further professional services.

CONCLUSIONS

Based upon the study the following conclusions appear to be valid:

1. The variables predictive of future adaptation patterns for the subject appear related to preadmission experiences of the child, especially placement in group caring facilities and living outside of the home environment at admission. Young people with such experiences should be regarded as at risk and may present a special population who require further services. Returning the child home after treatment is associated with positive adaptation.

2. Variables such as age at admission, frequency of parental involvement, length of residential care, and number of foster care placements are not correlated with positive adaptation.

3. The HSS appears to be a useful instrument, if utilized at discharge, to rate the outcome of subjects and, in turn, predict their subsequent adjustment in the community.

4. (+) Subjects evaluated at follow-up tended to enjoy greater success in school; tended to have higher levels of educational attainment; tended to be continuing in an educational setting; tended to enjoy a greater sense of community attachment as evidenced by the number of friends and church attendance; and, overall, tended to enjoy a greater sense of well being and comfort.

5. A positive adaptation rate of 69.34% indicated that the agency is having a programmatic impact upon a target population when compared to other similar studies.

6. Almost 50% of those classified at follow-up as negative adaptations experienced such an adaptation within the first three months following discharge from Orchard Place.

IMPLICATIONS AND RECOMMENDATIONS

Based on the study, a number of specific recommendations are presented which hopefully will serve to increase the effectiveness of the Orchard Place Program in meeting the needs of troubled youths.

First, consideration should be given for the development of some type of weighting system to be used in the area of foster care, such as has currently been developed in the area of special education. For instance, a weighting system has been in use for young people enrolled in special education identifying the level of need and, in turn, such a weighting is used to generate funds to provide needed services for the child. This system involved assigning a numerical value such as 1.8 up to 4.4. The index system is then used as a factor in how funds will be assigned to follow the child and provide services.

Consideration should be given for the development of an innovative weighting system for youth involved in foster care. Such a system could well be tied in with previous group care placements. If a youth has received such care, regardless of the nature of the facility, the youth would be weighted as a numerical index which would

be attached to increased funding. Such funding would then be utilized to focus on the unique needs of those who are particularly difficult to treat and who may be at risk for later maladjustment. Provision of such finds would enable the caring facility to secure and develop special programs tailored to the needs of youths who appear to be in most need.

For instance, a youth entering Orchard Place who may have previously been placed in several foster homes or group homes could utilize a very specific training program in learning how to become an autobody mechanic. Through a weighting system, funds would be allowed to grant the youth an opportunity for placement with some firm.

Certainly the psychosocial difficulties of the youth necessitating residential admission would be the area of further intervention and treatment. The caring facility would have the additional funds to purchase services for the youths that would enable them to return and function in the community effectively. Such a recommendation emphasizes the development of the weighting system and enables the facility and the child care takers to determine exactly what type of special program would need to be developed. Theoretically, the program could be highly prevocational and vocational in nature, or, could become an apprenticeship program, depending upon the needs of the youngsters.

Second, what occurs following discharge, is extremely significant for youths returning to the communities.

Re-entry into the community must be viewed as a critical time frame, but funds are often terminated after two weeks from discharge. Additional services, perhaps up to six months or more are needed to insure that the gains made while in residence are integrated into the family system.

Third, the HSS should routinely be incorporated as a part of the discharge procedure. Young people who are not scoring high, perhaps above 50 on the HSS, should be regarded as at risk and recommendations should be detailed to the family and/or the child care takers to be aware of needs in this area. This is not to suggest that the HSS is the best possible instrument for such purpose. It remains experimental and will certainly require refinement to insure that it is accurate. It may, however, prove to be a practical tool for use at discharge.

Fourth, further data should be collected on those who were able to adapt positively. It is known that such youths fared better in terms of every measure of this report. Although it would be feasible to study those regarded as negative adaptations, it may be advisable to begin studying carefully what the important variables were which enabled the youths to function successfully after discharge. Analysis of what is pathological or abnormal may inferentially say what is normal functioning, but such analysis does not serve to provide data which guides the activity or behavior on the part of child care takers to stimulate and promote positive functioning on the part of youths and their families. Overall,

it is reasonably accurate to say that those who were evaluated as positive group members had their needs met more adequately. However, many questions arise: what were the areas of critical need fulfillment? What needs have a higher priority for disturbed youth? Questions such as these must be answered to assist all youths in their development.

This study raised more questions than it apparently answered. The knowledge based for such work needs constant development and refinement in order to insure that it has practical use. The study was a beginning attempt to analyze one residential program and assess some areas which appear to be of significant meaning to staff and youth. Each such residential center is vastly different from another with divergent philosophies, approaches to treatment and different clients. These data gathered from one such center make a modest attempt to understand more accurately the process of helping clients and their families.

BIBLIOGRAPHY

BIBLIOGRAPHY

BOOKS

Allerhand, M.E. and R.E. Weber. Adaptation and Adaptability: The Bellefaire Follow-Up Study. New York: Child Welfare League of America, 1966.

American Association for Children's Residential Treatment Centers. From Chaos to Order: A Collective View of the Residential Treatment of Children. New York: Child Welfare League of America, 1972.

Dinnage, R., and M.L. Pringle. Residential Child Care: Facts and Fallacies. Great Britain: Longmans Press, Ltd., 1969.

_____. Residential Child Care: Facts and Fallacies. Great Britain: Longmans Press, Ltd., 1967.

Erikson, Eric. Childhood and Society. 2nd ed. New York: W.W. Norton and Co., 1950.

Garber, B. Follow-Up Study of Hospitalized Adolescents. New York: Bruner and Mazel, 1972.

Guildord, J., and F.R. Pand. Fundamental Statistics in Psychology and Education. New York: McGraw-Hill, 1973.

Guttentag, L., and E. Struening. Handbook of Evaluation Research. Beverly Hills: Sage Publications, 1975.

Hylton, Lydia. The Residential Treatment Center: Children, Program and Costs. New York: Child Welfare League of America, 1964.

Kadushin, A. Child Welfare Services. New York: Macmillan Co., 1967.

Knoblock, P. Educational Programming for Disturbed Children. New York: Syracuse University Press, 1964.

Masterson, J.F. Treatment of the Borderline Adolescent: A Developmental Approach. New York: Wiley, 1972.

O'Neal, P., and L.N. Robins. Deviant Children Grown Up: A Sociological and Psychiatric Study of Sociopathic Personality. Baltimore: Williams and Wilkines, Co., 1966.

Redl, E., and D. Wineman. Children Who Hate. New York: The Free Press, 1951.

Crisis in Child Mental Health: Challenge for the 1970s. New York: Harper & Row, 1972.

Suchman, E.A. Evaluative Research. New York: Sage Publications, 1967.

Taylor, D., and S. Alpert. Continuity and Support Following Residential Treatment. New York: Child Welfare League of America, 1973.

Weber, G., and B.J. Haberlein. Residential Treatment of Emotionally Disturbed Children. New York: Behavioral Publications, 1972.

Whitaker, J.K., and Trieschman, Albert. Children Away From Home: A Source of Residential Treatment. Chicago: Aldine Publishing, 1972.

PERIODICALS

Alt, H. "The Concept of Success in Residential Treatment --An Administrator's View," Child Welfare, XL (1964), 423-430.

Annesley, P.T. "Psychiatric Illness in Adolescence: Presentation and Prognosis," Journal of Mental Science, CVII (1961), 268-278.

Attkisson, McIntyre, and others. "A Working Model for Mental Health Program Evaluation," American Journal of Orthopsychiatry, 44 (October, 1974), 741-754.

Beavers, W.R., and S.Blumberg. "A Follow-Up Study of Adolescents Treated in an In-Patient Setting," Disordered Nervous System, XXIX (September, 1968), 606-612.

Beskind, H. "Psychiatric Inpatient Treatment of Adolescents: A Review of Clinical Experience," Comprehensive Psychiatry, III (December, 1962), 354-369.

Cameron, K. "Symposium on Inpatient Treatment of Psychotic Adolescents," British Journal of Medical Psychology, XX (1950), 107-118.

Carter, A. "The Prognostic Factors of Adolescent Psychoses," Journal of Mental Science, XXCVIII (1942), 31-81.

Davids, A., and P. Salvatore. "Residential Treatment of Disturbed Children and Adequacy of their Subsequent Adjustment: A Follow-Up Study," American Journal of Orthopsychiatry, XLVI (January, 1976), 62-73.

Errera, P. "A Sixteen Year Follow-Up of Schizophrenic Patients in an Out-Patient Clinic," Archives of Neurological Psychiatry, LXXVIII (1957), 84-87.

Gossett, J.T., and others. "Follow-Up of Adolescents Treated in a Psychiatric Hospital," American Journal of Orthopsychiatry, XLIII (July, 1973), 602-610.

_____, and others. "Follow-Up of Adolescents Treated in a Psychiatric Hospital," Adolescence, X (Summer, 1976), 197-211.

Gil, D. "Developing Routine Follow-Up Procedures for Child Welfare Services," Child Welfare, XVII (May, 1976), 229-240.

Hamilton, D.M., and others. "Results of Mental Hospital Treatment of Troubled Youth," American Journal of Psychiatry, CXVII (November, 1961), 811-816.

Hartman, E., B. Glasser, and L. Herrera. "Adolescent In-Patients: Five Years Later," Seminars In Psychology, I (February, 1969), 66-78.

Herstein, H. "The Challenge of Evaluation in Residential Treatment," Child Welfare, IV (March, 1975), 141-151.

King, L., and G.D. Pittman. "A Six Year Follow-Up Study of 65 Adolescent Patients: Predictive Value of Presenting Clinical Picture," British Journal of Psychiatry, CXV (1969), 1437-1441.

Levy, E.Z. "Long-Term Follow-Up of Former In-Patients at the Children's Hospital of the Menninger Clinic," American Journal of Psychiatry, CXXV (June, 1969), 1633-1639.

Luborsky, L. "Clinicians' Judgments of Mental Health: Speciman Care Descriptions and Forms for the Health-Sickness Rating Scale," Bulletin of the Menninger Clinic, XXXIX (1975), 448-480.

Masterson, J.F. "Prognosis in Adolescent Disorders," American Journal of Psychiatry, CXIV (June 1958), 1097-1112.

_____. "Prognosis in Adolescent Disorders: Schizophrenia," The Journal of Nervous and Mental Disorders, CXXIV (September, 1956), 218-232.

Mayer, M.F. "Program Evaluation as a Part of Clinical Practice: An Administrator's Position," Child Welfare, LIV (June, 1975), 379-395.

Milbon, F., and J.L. Massimo. "After Ten Years: A Follow-Up Study of Comprehensive Vocationally Oriented Psychotherapy," American Journal of Orthopsychiatry, XLIII (January, 1973), 128-132.

Morris, H.H., P.J. Escoll, and R. Wexler. "Aggressive Behavior Disorders of Childhood: A Follow-Up Study," American Journal of Psychiatry, CXII (May, 1956), 991-997.

O'Neal, P., and L.N. Robins. "Childhood Patterns Predictive of Adult Schizophrenia: A Thirty Year Follow-Up Study" American Journal of Psychiatry, CXV (November, 1958), 385-391.

Pappenfort, G., and W. Kilpatrick. "Child-Caring Institutions, 1966: Selected Findings from the First National Survey of Children's Residential Institutions," Social Service Review, XLIII (December, 1969), 448-450.

Potter, H.W., and H.R. Klein. "An Evaluation of the Treatment of Problem Children as Determined by a Follow-Up Study," American Journal of Psychiatry, XCIV (June, 1937), 681-689.

Robins, L.N., and P.O'Neal. "Mortality, Morbidity and Crime: Problem Children 30 Years Later," American Review, XXIII (1958), 162-171.

Rosenblat, A., and J. Mayer. "The Recidivism of Mental Patients: A Review of Past Studies," American Journal of Orthopsychiatry, XLIV (October, 1974), 697-707.

Sargent, H.D. "Methodological Problems of Follow-Up Studies in Psychotherapy Research," American Journal of Orthopsychiatry, XXX (May, 1960), 493-499.

Warren, W. "A Study of Adolescent Psychiatric In-Patients and the Outcome Six or More Years Later: I. Clinical Histories and Hospital Findings," Journal of Child Psychology and Psychiatry, V (1965), 1-17.

_____. "A Study of Adolescent Psychiatric In-Patients and the Outcome Six or More Years Later: II. The Follow-Up Study," Journal of Child Psychology and Psychiatry, VI (1965), 141-160.

Weiss, T., and B. Glasser. "Social Adjustment of Adolescents Discharged from a Mental Hospital," Mental Hygiene, XLIX (1965), 378-384.

UNPUBLISHED SOURCES

Crow, M.R. "An Analysis of the Development of Orchard Place: A Residential Treatment Center for Disturbed Children," Unpublished Ed.D. dissertation, Drake University, 1976.

Johnson, L., and J.H. Reid. "An Evaluation of Ten Years Work with Emotionally Disturbed Children," Seattle: Ryther Child Center, 1947.

Miller, W.T. "The Adolescent in Residential Treatment: A Twenty-Year Follow-Up Study," Unpublished manuscript, Topeka State Hospital, 1971.

Miller, W.T. Personal Correspondence, June 21, 1976.

Shyne, A.W. "Research on Child-Caring Institutions." New York: Child Welfare League of America, 1971. (Mimeographed)

APPENDIXES

APPENDIX A

FOLLOW-UP QUESTIONNAIRE

Read to Client:

All information is confidential and no client will be identified. Only statistical information will be collected and presented as the final report.

DATE _____

INTERVIEWER: _____

1. Name of former resident: _____ Age: _____

   Present Address (if known) _____

   Phone: _____

2. Date of Discharge: _____

   (In questions where client is answering, change subject of sentence accordingly.)

3. What is the longest period of time the person has worked at a job? _____

   a) How long at present job? _____

   b) At how many jobs has the person been gainfully employed during the past two calendar years? _____

4. Has the person been: (check one)

   a) Married Yes( ) No( ) How long? _____
   b) Divorced Yes( ) No( )
   c) Children Yes( ) No( ) How many? _____
   d) Friends Few( ) Some( ) Many( )
      (0-1) (2-4) (+5)
   e) Church Affiliation Yes( ) No( )

5. Where is the person living not? (check one)

   a) Parent's home ( ) d) Foster home ( )
   b) His/Her own home ( ) e) Boarding school ( )
   c) Relative's home ( ) f) Psychiatric hospital or

residential treatment center( )
g) Group home ( )
h) Other (explain) ( )

6. Does he/she attend school? (check one)

Yes ( ) No ( ) If yes, grade:_____

If no, highest grade completed:_____

If now attending school, in what school activities does the person participate? (check one or more)

Sports( ) Drama( ) Band( ) Student Council( ) Other( )

Did person complete high school? Yes ( ) No ( )

7. If now attending school, how would you view current school adjustment? (check one)

Very good( ) Good( ) Fair( ) Poor( ) Very Poor( )

8. Has the person received any outpatient psychiatric treatment since he/she left Orchard Place? (check one)

Yes( ) No( ) If yes, how long was treatment?_____

9. Has the person been a patient in a psychiatric hospital since Orchard Place discharge? (check one)

Yes ( ) No ( )

If yes, where and for how long?_____

Facility name:_____

If answer to Question #9 is No, go to Question #11.

(Note each confinement) Total # of days

a) Date of confinement: From: / / To: / / _____

b) Date of confinement: From: / / To: / / _____

c) Date of confinement: From: / / To: / / _____

10. Were any hospitalizations involuntary? Yes( ) No( )

11. Has subject been known to the police since discharge?

Yes ( ) No ( )

12. If yes, has subject been jailed? Yes( ) No( ) Offense

    a) Date of incarceration: From: / / To: / / _____

    b) Date of incarceration: From: / / To: / / _____

    c) Date of incarceration: From: / / To: / / _____

13. What were precipitating causes of hospitalizations, jail or seeking help? (check one or more)

    a) Loss of parent(s) ( )
    b) Death of spouse ( )
    c) Divorce ( )
    d) Job change ( )
    e) Move to new community ( )
    f) Onset of illness ( )
    g) Other (explain) ( )

    _____

    _____

    _____

14. How would you rate the person's present adjustment compared to when the person left Orchard Place? (check one)

    Better ( )

    Same ( )

    Worse ( )

15. Remarks. Please make any additional comments you feel may be helpful in understanding the person's adjustment since discharge.

    _____

    _____

    _____

    _____

    _____

    _____

INTERVIEWER: Thank the person for participation in the survey.

APPENDIX B

HEALTH-SICKNESS RATING SCALE (MODIFIED)

NAME_____

At 100: An ideal state of complete functioning integration, or resiliency in the face of stress, of happiness and social effectiveness.

Examples: Some patients who complete treatment, and some who come for and need only "situational" counseling.

(From 99 to 76: Degrees of "everyday" adjustment. Few individuals in this range seek treatment.)

At 75: Inhibitions, symptoms, character problems become severe enough to cause more than "everyday" discomfort. These individuals may occasionally seek treatment.

Examples: Patients with very mild neurosis or mild addictions and behavior disorders begin here and go on down, depending on severity.

70: *mild depression.

At 65: Generally functioning pretty well but have focalized problem or more generalized lack of effectiveness without specific symptoms.

Examples: Clearly neurotic conditions (most phobias, anxiety neurosis, neurotic characters.)

60: verbally hostile; *anxiety-preoccupied with sexual material.

55: *somewhat aggressive: suspicious.

At 50: Definitely needs treatment to continue work satisfactorily and has increasing difficulty in maintaining himself autonomously. Patient may either be in a stable unsatisfactory adjustment (where most energy is bound in the conflicts) or an unstable adjustment from which he will likely regress.

Examples: Severe neurosis such as severe obsessive-cumpulsive, may be rated at 50 or lower, rarely below 35. Some compensated psychosis. Many character disorders, neurotic depressions.

50: *withdrawal; anxiety.

50: *withdrawal; depression.

40: stealing, outbursts, fighting, negativism; passive provocation; anxiety; *depression.

At 35: Examples: Most borderline schizophrenias; severe character problems. Psychotic depressions may be this high, or go all the way to "0".

35: *fighting; suspicious; depressed

30: *running away; accident prone; concern with homosexual tendencies--presently seemed to be controlling it; far behind in school due to IQ; anxiety; "somatic complaints"; speech difficulty.

30: rocking when anxious; *extremely grandiosity; *anxiety.

At 25: Obviously unable to function autonomously. Needs hospital protection, or would need it if it were not for the support of the therapist.

Examples: Most clear-cut overt psychosis, psychotic characters, severe additions (which require hospital care). Also, those who must be transferred to another hospital on leaving the Adolescent Unit.

25: withdrawal; extreme grandiosity; *anxiety; somatic complaints; restless, agressive, rocking.

(From 24 to 1: Increased loss of contact with reality; need for protection of patient or others from the patient; high degree of regression. (Suicide attempts often rated at 20.)

Examples continued:

20: tantrums; fighting, *self-injurious; preoccupation with sex; strange, bizarre; severe hyperactivity; cajoles, teases, curses, threatens, screams.

20: *withdrawal; *suicide attempt; hallucinations; somatic delusions.

15: *tantrums, destructive behavior, negativism; bizarre, transient delusions; auditory hallucinations, fears of staff; yelling and screaming.

15: mutism; *hallucinations.

15: tantrums, crying, injures animals; withdrawal; *molests others; bizarre, mannerisms, transient delusions; learning so slowly as to be unable to stay in school; moderate hyperactivity; *severe passive-dependency; and unspecified infantile clinging behavior.

At 10: Extremely difficult to make any contact with patient. Needs close ward care. Not much change of continued existence without care.

Examples: "closed ward" patients, such as chronic schizophrenics, excited manics, profound suicidal depressions.

10: Mute with exception of crying; withdrawn; refusal to eat; sex play between patient and brother; bizarre; *felt she had been impregnated when nurse administered enema at church camp; depression.

At 0: Any condition which, if unattended, would quickly result in the patient's death, but not necessarily by his own hand.

Examples: Completely regressed schizophrenics (incontinent, out of contact) who require complete nursing care, tube feedings.